PROCEDURE

ORIGINAL DATE:	01/95
Revised Date:	**12/07**

SUBJECT: WOUNDS - ASSESSMENT, PREVENTION AND TREATMENT OF

PURPOSE: To outline the procedure followed by clinicians in the course of evaluating and treating wounds.

All patients admitted to the VNA will have an assessment of skin integrity including wounds. These will be evaluated and treated using the following procedure/protocol:

Procedure/Protocol

I. Assessment of Risk Factors

A. Every patient, upon admission to the VNA and on an ongoing basis, especially whenever the patient's condition changes, will be assessed to determine skin integrity and the presence of factors which increase the risk for development of loss of skin integrity and/or wound deterioration.

RATIONALE:

1. ***Ongoing evaluation of a patient's risk for developing wounds is the first step in prevention or treatment intervention.***
2. ***The presence of one or more of the listed risk factors increases the chance for development of skin breakdown. Since the same factors that cause wounds can delay healing, ongoing assessment of risk for patients WITH wounds supports treatment.***

B. Risk factors include: moisture from diaphoresis or incontinence, overly dry skin, poor nutrition, advanced age, acute or chronic disease, i.e.- cardiovascular disease, DM, infectious disease, anemia, immobility or decreased level of activity, diminished sensory perception and the potential for mechanical injury from shearing forces, friction and pressure. Risk factors will be documented in the medical record and a PREVENTION PLAN of care developed to reduce or remove the risk factor(s).

II. Wound Classifications

A. Pressure ulcer classification is completed according to the staging system developed by the NPUAP (*Attachment #1 – "National Pressure Ulcer Advisory Panel"*) , and WOCN (*Attachment #2 – "Pressure Ulcer Assessment and Treatment Plan Summary"*).

B. Other wound types (i.e., venous, arterial and surgical wounds) are classified as partial or full thickness.

C. Wounds are usually classified into two "main" categories.

1. Surgically created wounds include all incisions and excisions of lesions.

2. Nonsurgical wounds include all skin lesions that occurred as a result of trauma pressure or pathologies such as venous insuffiency, arterial insufficency and diabetes.

A chronic wound is a wound that has failed to heal through an orderly and timely process.

RATIONALE: Accurate and quantifiable determination of wound etiology can guide treatment decisions and help evaluate effectiveness of care. Furthermore, assessment and documentation of a wound is considered a skilled clinical service.

III. Wound Assessment

A. Wound measurements must be done upon admission and once a week until the patient is discharged or his/her wound is healed. It is important to document wound measurements as follows:

1. Wounds are always measured in centimeters.
   a. ***Wound LENGTH*** represents the longest area of tissue breakdown (head to toe measurement.)

   b. ***Wound WIDTH*** represents the widest area (side-to-side measurement.)

   c. ***Wound DEPTH*** represents the deepest area of tissue breakdown. When measuring wound depth, insert a swab and gently probe to find the deepest point. It is important to document where in the wound the measurement was taken.

B. Wound edges should be gently probed to assess whether or not there is any undermining or tunneling. Undermining and/or tunneling must be documented according to: 1.) location (clock position) and 2.) dimensions in centimeters. When undermining or tunneling is present, it is important to monitor the healing process to make certain that the wound is healing from the bottom up.

C. The wound bed should be assessed at each dressing change visit for the presence of:

1. Necrotic tissue which is usually black and hard, sometimes soft with a tinge of yellow.

2. Fibrinous tissue or slough which is yellowish and threadlike denatured proteins that cannot be removed.

3. Granulation tissue is pink-red, beefy tissue that may bleed easily. This tissue has to replace the lost dermis.

   A percentage of non-viable tissue by type (see # 1 and #2 above) and granulation tissue (when present) is to be documented.

4. Epithelium is a pink, fragile-looking layer of new epithelial cells.

5. Miscellaneous debris or other foreign materials, i.e. - suture remnants.

6. Odor of the wound.

7. Exudate the amount and color of the wound drainage.

D. Include evaluation of the surrounding skin, i.e. - red, inflamed, clinical signs of infection and maceration.

E. A treatment plan is devised based on the clinical assessment, use of HHVNA wound formulary and physician's orders.

RATIONALE: Initiate complete wound assessment of any existing area of skin breakdown as an integral part of the on-going skin care program. Wound measurements provide baseline data to evaluate patient response and progress over time. Complete and appropriate documentation of wound assessment builds support for skilled service and provides evidence of assessment and re-evaluation of patient's needs.

F. All patients will have their skin integrity assessed upon admission and every week thereafter.

G. Patients will be interviewed and all previously healed wounds evaluated upon initial assessment and as part of the ongoing weekly assessment.

IV. Wound Healing

A. Establish a healthy environment for wound healing by addressing factors that impede healing such as: infection, necrosis, non-selective debridement, inflammation, medications such as steroids and anti-inflammatories, hypoxemia, vascular insufficiency, protein depletion, concurrent illness, malnutrition, pressure, hyperglycemia, premature wound closure, lack of wound hydration and maintenance of normal wound bed temperature.

RATIONALE: The removal of impediments to healing allows natural processes to occur. Wound healing progresses through a number of highly interdependent stages.

V. Patient/Caregiver Teaching

Patient/caregiver education is an ongoing component of a wound management program to promote appropriate care and treatment and prevent further problems.

A. Assess all patients and caregivers for learning readiness and for specific learning methods.

B. Identify and communicate to patients/caregivers a teaching/learning plan.

C. Provide them with oral and written instructions and materials for wound care as needed.

D. Evaluate the effectiveness of the teaching/learning plan and modify it on an ongoing basis. Teaching guidelines for the patient with a wound and at risk for one should encompass the following:

1. Skin integrity maintenance and prevention.

2. Management of incontinence/moisture.

3. Nutrition.

4. Pressure relief measures.

5. Mobility, seating and positioning issues. Consult a Rehab team member as needed for assessment, education and follow-up.

6. Signs and symptoms of infection.

7. Effective pain management.

RATIONALE: Patient teaching guidelines promote consistent and comprehensive patient and caregiver education. Documentation of patient teaching reflects comprehensive patient education and the delivery of skilled care.

E. Pertinent information will be added to the skilled care plans and HHA care plan accordingly.

VII. WOUND CARE PRACTICES

A. Individuals authorized to perform wound assessment and wound care include RN, LPN/LVN, PT/ PTA, and OT/COTA. According to Agency policy #2460 a Home Health Aide may change a simple, non-sterile dressing on dried, reddened or scabbed areas after instruction by the primary clinician. This must be added to both care plans. If the HHA notices any change in the wound he/she will notify the primary clinician or the HHA Department (who will notify the clinician to re-evaluate the wound). This also is to be added to the HHA's care plan.

B. Documentation will reflect the important points of wound assessment - description of the wound including wound edges, wound bed, surrounding skin, wound drainage, pain; and measurement of the wound. Documentation should also demonstrate compliance with the plan and show patient response to progress. Documentation guidelines are as follows:

1. The initial assessment includes a complete baseline description of the skin and/or wound and pertinent facts, such as the patient's or caregiver's limitations, to justify skilled care.

2. The plan of care and physician verbal orders include site, procedural details, and frequency.

3. Ongoing documentation reflects significant clinical findings, performance of skin and/or wound care, patient/caregiver teaching, patient response, plan for continued teaching, or progress and the effectiveness of the plan of care. The outcomes must

realistically reflect the patient's situation and the potential for response or improvement. In addition, coordination and communication of care, and physician contact must be included in the medical record.

4. The agency will investigate adverse events for appropriateness of care and will perform quarterly chart audits to determine policy compliance.

C. Physician Orders: Must be complete for skin and wound care, including site, details of the procedure, and frequency of intervention.

Approved Policy Committee: 12/18/07

"National Pressure Ulcer Advisory Panel (NPUAP) For Pressure Ulcers"

STAGE 1: Nonblanchable erythema of intact skin the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may be indicators.

STAGE 2: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow center. **The wound bed is red/pink, without slough**

STAGE 3: 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.

STAGE 4: 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 **(tunnels)** are **often** associated with Stage 4 pressure ulcers.

Unstageable: Full thickness pressure ulcer that cannot be accurately staged until the deepest viable tissue layer is visible. These wounds are covered with eschar and/or slough.

Deep tissue injury: Purple or maroon localized discolorization of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The skin is not open. This is a heralding sign of a pressure ulcer.

Attachment #1

"PRESSURE ULCER ASSESSMENT AND TREATMENT PLAN SUMMARY"

Presssure ulcer: any lesion caused by unrelieved pressure resulting in damage of underlying tissue, usually located over bony prominences and are staged to classify the degree of tissue damage. Shear and friction may be contributing factors.

Nursing Care Plan	*Intervention*
Ongoing Pressure Ulcer Risk Assessment	Complete regular Pressure Ulcer Risk Assessment. Evaluate patient for: • Impaired mobility & sensory perception; • Presence of skin moisture; • Inadequate nutritional intake; • Presence of external mechanical forces such as shear and friction.
Maintain/Improve Tissue Tolerance to Pressure	• Conduct regular skin inspection, especially of bony prominences; • Avoid excess moisture by maintaining hygiene and skin protection; • Avoid excess dryness and exposure to cold; • Avoid massage over bony prominences; • Assess nutritional status and monitor total nutritional intake, including enteral or parenteral support.
Protect Against External Mechanical Forces	• Encourage systematic and frequent repositioning of patient; • Use pillows/positioning devices to prevent contact between bony prominences; • Use lifting devices (i.e., bed linen) to move patient; • Obtain pressure-redistribution devices such as 4-inch foam, static air, alternating air, or low air loss mattress overlay.

NOTE: The needs of every patient are unique. The restrictions of implementing a patient care plan as a result of particular patient needs can not be captured in a guideline. The plan provides a summary of guidelines which may, or may not, be feasible, practical, or complement the primary goal of care. It is the responsibility of the health care professional to ensure that the care plan is consistent with the overall goal of care.

Reference(s):

1. Pressure Ulcers in Adults: Prediction and Prevention. Quick Reference Guide for Clinicians Number 3. US Department of Health and Human Services, AHCPR Publication No. 92-0050, May, 1992
2. Pressure Ulcer Treatment. Quick Reference Guide for Clinicians Number 15. US Department of Health and Huam Services, AHCPR Publication No. 95-0653, December, 1994
3. WOCN OASIS Guidance Document. Wound Ostomy and Continence Nurses Society, rev 7/2006
4. NPUAP Pressure Ulcer Stages. National Presuer Ulcer Advisory Panel , rev 2007.

Attachment #2