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| SUBJECT: PROTOCOL AND PRACTICE GUIDELINES | NO.  |
| SUBJECT: Debridement MethodsPRACTICE GUIDELINES: Wounds with necrotic or dead tissue must be debrided in order to optimize the speed of healing. Wounds that have been debrided generally heal more quickly.There are four basic types of debridement methods recognized by HCFA. These four methods are:1. Surgical: This type of debridement is generally considered to be the last resort of debriding a wound. It requires the use of a scalpel or other sharp instrument. Surgical debridement is performed by a physician and involves cutting of dead or necrotic tissue from a wound. It may also involve the removal of necrotic tissue surrounding the wound.
2. Mechanical: This involves the removal of necrotic tissue, slough, or other impediments to wound healing by means of scrubbing, scraping, otherwise manually removing dead tissue. An example is scrubbing the wound with a 4x4 to remove eschar. Using wet to dry gauze and then pulling the dead tissue with the dry gauze is also considered mechanical debridement. Mechanical debridement is generally more desirable than surgical, though it too can be painful for the resident.
3. Chemical: Chemical debridement involves the removal of dead tissue by means of applying an enzymatic agent to the necrotic tissue. Chemical debridement is generally less painful than the two alternatives above. However, care should be taken when using enzymatic agents, as they can also dissolve viable tissue. Santyl is safe and does not harm viable tissue. This is the only debride currently recommended.
4. Autolytical: Autolytic debridement is by far the most desirable means of debridement, as it involves very little pain for the resident, requires less nursing time, and is by far the easiest means of debridement. Autolytic debridement is simply allowing the body to debride the necrotic tissue on its own. Generally, it is very important to use a dressing which promotes moist wound healing. Moist wound healing provides the ideal environment for autolytic debridement by:
5. Insulating the wound and keeping it at 98.6 decrees (F), which is optimum healing temperature.
6. Bathing the wound in fluid filled with phagocytes, which eat away necrotic tissue and keeps the wound clean.
7. Keeping the nerve ending bathed in fluid to minimize pain. Certain wound dressings provide a moist environment and allow the body to debride the wound without surgical, mechanical, or chemical means. These dressing should be left in place for as long as possible (up to 7 days) to ensure quick and completed debridement.
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| SUBJECT: PROTOCOL AND PRACTICE GUIDELINES | NO.  |
| PRACTICE GUIDELINESTYPE: Skin Tears, Abrasions, LacerationsACTIONS INTERVENTIONS

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| Assess wound. Provide emergency care if needed. | Assess reason for wound (if other than surgical). |
| Contact physician. | Assure proper handling and transfer techniques were used. Retrain as needed. |
| Cleanse area with normal saline (unless specified otherwise by physician). | Assess need for protective clothing, i.e., long sleeves, geri-gloves, geri-legs, etc. |
| Treat area per physician’s orders. | Observe environment for need of protective equipment, i.e., padding for wheel chair arms, legs, side rails, etc. |
| Fill out a RiskWatch report for all new areas. |  |
| Write descriptive initial note. |  |
| Put on Hot Rack for monitoring and follow up. |  |

TYPE: Perineal Excoriations ACTIONS INTERVENTIONS

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| Cleanse with soap and water. Pat dry. DO NOT RUB. | Strive to keep resident clean and dry. |
| Apply moisturizing lotion or skin conditioning cream, if appropriate. Apply moisture barrier with each incontinent episode. |  |
| Assess reason for incontinence. |  |
| Determine if candidate for B & B Program for incontinence management program. |  |
| Chart all of the above. |  |

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| SUBJECT: PROTOCOL AND PRACTICE GUIDELINES | NO.  |
| TYPE: RashesACTIONS INTERVENTIONS

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| Assess resident. | If allergy determined, stop use of product(s) responsible. |
| Notify physician. | Check resident’s nails and trim if needed. |
| Cleanse area with soap and water. Pat dry, DO NOT RUB. | Check resident frequently to determine need for further topical or po treatment. |
| Follow physician’s orders for po’s (orals) and/or topical. |  |
| Explain physician’s findings, orders, treatment, etc. to the resident. | Assess need for analgesics. |
| If allergy determined, note in all appropriate areas of clinical record. |  |
| Chart all of the above. |  |

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| SUBJECT: PROTOCOL AND PRACTICE GUIDELINES | NO.  |
| TYPE: Venous Leg UlcersMost leg ulcers are caused by venous insufficiency. Some of the characteristics of venous ulcers that differentiate them from other leg ulcers are:1. Irregular shape
2. Swelling or edema-generalized.
3. Brown or red pigmentation on the perimeter of the ulcer.
4. Pain relief when leg is elevated.
5. Shallow wound with diffuse edges.
6. Normal pulses.

SPECIAL NOTE: It is very important to have a proper diagnosis for the healing of a leg ulcer. If a leg ulcer’s etiology is not venous insufficiency (i.e., arterial or diabetic), compression is contraindicated. DO NOT use compression on these wounds.ACTIONS KEY POINTS

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| Cleanse wound with wound cleanser or normal saline. | Remove gross contaminants from wound bed. |
| Allow area around wound to air dry or pat dry with gauze. | Drying allows adhesive to adhere to skin. |
| Follow physician’s treatment orders |  |

 Venous ulcers require moist wound area to heal. Venous leg ulcers may be referred to the wound clinic or wound consulting firm with a physician’s order. |
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| SUBJECT: PROTOCOL AND PRACTICE GUIDELINES | NO.  |
| TYPE: Arterial or Diabetic Leg Ulcers Arterial and/or diabetic ulcers have very different characteristics than venous leg ulcers. They are characterized by:1. Even, “punched out”, smooth wound margins
2. Frequently necrotic
3. Pain increased during elevation of leg
4. Distal location (over bony prominence of leg)
5. Thin, shiny, dry skin
6. Thickened toenails
7. Diminished or absent pulse.

**SPECIAL NOTE: Compression is contraindicated for arterial or diabetic ulcers. Also, remember that elevation of leg may increase pain.** ACTIONS KEY POINTS

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| Cleanse wound with wound cleanser or normal saline. | Removes gross contaminants from wound bed without toxicity. |
| Allow area around wound to air dry or pat dry with gauze. | Drying allows adhesive to adhere to skin. |
| Follow physician’s treatment orders |  |
| Change position of resident every two (2) hours or more often according to need. | Initiate the facility’s turning and positioning and mobility programs are essential in reducing risk of pressure sores. |
| Identify and use pressure-relieving devices, i.e., special mattresses, boots, chair pads, etc. | Reduces incidence and severity of pressure sores. |
| Dietician to complete nutritional assessment with appropriate recommendations and documentation. | Includes review and on-going monitoring of fluid and Nutritional intake and lab value. |
| Provide Range of Motion as indicated. | Active and Passive ROM promotes activity and reduces effects on pressure on tissue and may assist with circulation. |
| Keep family and resident informed and very involved in decisions, care planning, etc. | Encourage resident/family participation in decision process and informed progress or lack of. |

Arterial or Diabetic leg ulcers may be referred to the wound clinic or wound consulting firm with a physician’s order. |
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| SUBJECT: PROTOCOL AND PRACTICE GUIDELINES | NO.  |
| TYPE: Surgical WoundsACTIONS KEY POINTS

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| Cleanse wound with wound cleanser or normal saline. | Removes gross contaminants from wound bed without toxicity. |
| Allow area around wound to air dry or pat dry with gauze. | Drying allows adhesive to adhere to skin. |
| Follow physician’s treatment orders |  |
| Change position of resident every two (2) hours or more often according to need. | Initiate the facility’s turning and positioning and mobility programs are essential in reducing risk of pressure sores. |
| Identify and use pressure-relieving devices, i.e., special mattresses, boots chair pads, etc. | Includes review and on-going monitoring of fluid and Nutritional intake and lab value. |
| Dietician to complete nutritional assessment with appropriate recommendations and documentation. | Includes review and on-going monitoring of fluid and Nutritional intake and lab value. |
| Provide Range of Motion as indicated. | Active and Passive ROM promotes activity and reduces effects of pressure on tissue and may assist with circulation. |
| Keep family and resident informed and very involved in decisions, care planning, etc. | Encourage resident/family participation in decision process and informed of progress or lack of. |

Surgical wounds may be referred to the wound clinic or wound consulting firm with a physician’s order. |
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