Nightingale Home Healthcare™

Nightingale™ Visiting Nurses

Aspire™ Home Healthcare

Home Care Providers

Wound Care Protocol

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Purpose:

1. To ensure optimal healing of wounds.
2. To identify type of wound in order to provide proper wound care.
3. To instruct PT/CG in the understanding of wound care and to know what symptoms to report to home health clinicians and/or MD should they suspect infection or worsening of wound.
4. To provide protocol for clinical staff providing wound care;

Expectations:

1. Wounds are to be measured on the first visit of each week and should be measured by the same **Registered Nurse** clinician for consistency.
2. Where a registered nurse and licensed practical/vocational nurse is caring for the patient as a team the RN shall:
    a. Coordinate the care
    b. Measure the wound weekly and provide oversite and direction for the LPN/LVN
    c. Revisit the patient when the LPN identifies a decline in the wound preferably the day of LPN visit and/or within 24 hours if the visit is late in the evening and the visit can wait.
    d. Re-evaluate wounds with changes in condition and report to the physician wound status
    e. Revise plan of care with treating physician.
3. The LPN/LVN shall:
    a. Immediately report any changes in the patient's condition and wound to the RN case manager,
    b. If the LPN/LVN is unable to reach the RN Case manager; the Clinical Director will be notified so a RN visit can be schedule to reassess the patient's wound, unless the RN/Director advises to send the patient to the Emergency Room.

4. Documentation of wounds
    a. The professional staff will utilize the wound care tab within the electronic medical record for all wounds to ensure the description of the wound is thoroughly documented.
    b. The RN shall document supervision of the LPN/LVN in cases with team assignments.
    c. All changes in wound condition shall be reported to the physician and documentation will include the individual whom the nurse spoke to; what orders were provided; and/or what direction was provided.
    d. All changes in care noted by the LPN/LVN shall be documented, along with notification of the RN case manager and/or Clinical Director or others

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5. Wounds are to be measured using disposable paper rules and sterile cotton-tip applicators including:
    a. Length: from 12:00 to 6:00 (regardless of wound location).
    b. Width: from 3:00 to 9:00
    c. Depth: from the deepest part of the wound
    d. Undermining: Measurements using position on a clock, including depth of undermining.
    e. Tunneling: Measurements using position on a clock, including depth of tunneling.
    f. Description of wound and surrounding area including drainage, slough, color, odor, bone/muscle exposure, eschar, or any other observations to clearly describe the wound.

6. All measurements will be recorded in centimeters and shall be recorded on all:
    a. SOC, ROC, Re-certifications, regardless of the day of the week and then first visit of week thereafter.
    b. Changes in wound assessment

7. Wounds to be identified and if pressure wound, stage must be identified.
    a. Pressure wounds to be identified and documented by bony prominence.
    b. Wounds to be identified and numbered in documentation and orders.
    c. Numbered wounds to be addressed separately in orders.
        i. Exception: if wound care is the same for all wounds you may group together.

8. Clinical Orders:
    a. Each wound must be labeled by number and location
    b. Each wound must have specific orders
    c. If patient and/or Caregiver will be participating in the wound; orders should reflect both and skilled nurse performing wound care.
    d. Examples of writing wound care orders:
        i. *Example #1:* Wound #1, sacrum pressure ulcer, stage 2 to be cleansed 3 times a week and prn by with NS/wound cleanser, pat dry, apply hydrocolloid dressing or protective foam adhesive dressing.
        ii. *Example #2*: Wounds # 1,2,3,4 to be cleansed daily with NS and pat dry, loosely pack with moisten NS gauze and cover with petroleum gauze, followed by dry dressing and secured with paper tape. PT/CG to perform wound care on non-SNV.
        iii. *NOTE:* For example #2 – The type of wound, the location of the wound, the size of the wound and the identifying number of the wound must be clearly identified in your assessment note.

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9. Wounds managed by Podiatrist, Other MD, or Wound Care Clinic
    a. Surgical wounds or wounds being managed only by Podiatrist, other MD, or Wound Care Clinic must also be included in your clinical orders.
    b. The telephone number of the physician treating the wound should also be included in the clinical orders.
    c. Examples of orders:
        i. *Example:* Wound Care is managed by Dr. XXXX. All wound care orders and changes to wound are to be reported and called to: telephone #: _____ Wound #1 care includes: XXXXX ….SN to …
        ii. If NGHHC is providing the care but wound managed as above: the RN needs to collaborate with the physician on the orders but also update the primary care physician.

10. Wound care supplies:
    a. Use generic terms for wound care products instead of specific brand names unless the physician specifically orders a brand name dressing.
    b. Examples of wound care supplies include:
        i. petroleum gauze (Xeroform,
        ii. Vaseline, Adaptic);
        iii. non-adherent dressing (Telfa);
        iv. transparent dressing (Tegaderm); and/or
        v. hydrocolloid (Duoderm).

11. If a wound heals during the certification period, remove care from Clinical Orders as "met" but do not renumber wounds.

12. Wound care orders will be rewritten on every re-certification, resumption of care (ROC) with any changes in wound care. If a wound is healed change the numbers on wounds at this time.

13. RNs must re-evaluate wound care patients weekly to ensure the current treatment is effective.

14. Wounds must be checked and documented at every SN visit.

15. Wounds without improvement:
    a. If no improvement has been noted as evidenced by wounds decreasing in size, healing, drainage, and etc., the Registered Nurse case manager must call the MD/Wound Clinic to report concerns and to obtain new wound care orders.
    b. These calls must be documented in visit note or call log. Note date, time, with whom you spoke with, and result of contact.
    c. Changes in treatment must be documented as updated Clinical Orders in the POC.

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16. Coordination of Care:
    a. Coordination with Wound Care Clinics is to be documented in visit note or call logs following wound care center visits.
        i. If orders are faxed to the office, the clinical coordinator/clinical director will enter the Clinical Orders and the call log will be forwarded by email to the SN.
        ii. If SN receives orders, document the communication in a call log/visit note and enter any changes in the Clinical Orders.
    b. The registered nurses will education to patients/caregivers and LPN/LVN to all changes to the plan of care and the communication will be documented in a case conference note.
    c. When education is complete, discharge the teaching clinical order as “MET.”

17. OASIS Wound Care Documentation
    a. All new hires are provided training regarding Medicare regulation for documenting OASIS Assessments.
    b. Skilled staff are required to take and successfully pass
        i. the Medicare Competency Programs and
        ii. the OASIS Competency Training