Nightingale
Home Healthcare

Nightingale University
Wound Care Protocol

HomeCare Elite
2008 TOP AGENCY

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... Wound Care Protocol

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.

Expectations:

1. Wounds are to be measured on the first visit of each week and should be measured by the same clinician for consistency. Coordination with all SN's caring for the patient should be arranged. (RN/LPN teams)
2. Wounds are to measured
   - Length: from 12:00 to 6:00 (regardless of wound location).
   - Width: from 3:00 to 9:00
   - Depth: from the deepest part of the wound
   - Undermining: Measurements using position on a clock, including depth of undermining.
   - Tunneling: Measurements using position on a clock, including depth of tunneling.
3. Disposable paper rulers are available from supplies to measure length/ width. Cotton-tip applicators or swabs should be used to measure depth.

4. All measurements will be recorded in centimeters.
5. Wound measurements will be recorded on all SOC, ROC, Recertifications, regardless of the day of the week and then first visit of week thereafter.
6. Wounds to be identified and if pressure wound, stage must be identified.
   - Pressure wounds to be identified and documented by bony prominence.
   - Wounds to be identified and numbered in documentation and orders.
   - Numbered wounds to be addressed separately in orders. (exception: if wound care is the same for all wounds you may group together).

Clinical Orders:

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.

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 gauze, followed by dry dressing and secured with paper tape. PT/CG to perform wound care on non-SNV.

****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.**

- Surgical wounds or wounds being managed only by Podiatrist, other MD, or Wound Care Clinic must also be included in your Clinical Orders. If phone number is known, include in order.

Example: Wound #1 managed by and cared for by _____.

If NGHHC is providing the care but wound managed as above:

Example: Wound #1 managed by _____.

- Use generic terms for wound care products instead of specific brand names
  Ex:
  petroleum gauze (Xeroform, Vaseline, Adaptic)
  non-adherent dressing. (Telfa)
  transparent dressing (Tegaderm)
  hydrocolloid (Duoderm)
- If a wound heals during the certification period, **remove care from Clinical Orders as "met" but do not renumber wounds.**

7. Wound care orders will be rewritten on every RC and ROC. If a wound is healed change the numbers on wounds at this time.
8. RNs must re-evaluate their wound care patients weekly for patients requiring 2 or more visits a week, and bi-monthly for those patients scheduled for 1x week visits. Evaluate if current treatment is effective. Wounds must be checked and documented at every SN visit.
9. **If no improvement has been noted as evidenced by wounds decreasing in size, the RN CM needs to call the MD/Wound Clinic to obtain new wound care orders.** These calls must be documented in visit note or call log. Note date, time, whom you spoke with, and result of contact. Changes in treatment must be documented as updated Clinical Orders in the POC.

10. Coordination of care with Wound Care Clinics is to be documented in visit note or call logs following wound care center visits.
    - If orders are faxed to the office, the CC will enter the Clinical Orders and the call log will be forwarded by email to the SN.
    - If SN receives orders, document the communication in a call log/visit note and enter any changes in the Clinical Orders.
11. Education to patients/caregivers regarding wound care needs to be documented in the visit note. When education is complete, d/c the teaching clinical order as "MET."