Wound Consults

Objectives:

- Discuss recent changes to the Wound Consult Process.
- Outline the process for obtaining a wound consult.
- Outline the process for initiating Guideline orders (skin tears, masd, stage 1 & 2 pi’s).

BACKGROUND

- Two teams were consulted for wounds: the Simple Wound team (Wound Ostomy Continence Nurses) and the Complex Wound team (an Advanced Practice Provider led consultation service for Plastic Surgery).

- Traditionally, the WOC Nurse team consulted patients with MASD, Stage 1, and Stage 2 pressure injuries and skin tears.

- The Complex Wound team consulted on patients with stage 3 and 4 pressure injuries, DTIs, severe MASD, complicated skin tears, DFU, VSD, PVD, PG, and Caliciphylaxis.

ASSESSMENT

- Because there were two processes to consult for a wound and due to inadequacies in pressure injury staging by bedside nurses, often the wrong team would be consulted. This resulted in both teams reviewing patient cases and triaging via pager.

- The process was inefficient, not standardized, and confusing.

- It also did not align with continuity of care from the same provider during the duration of wound treatment.

CHANGES

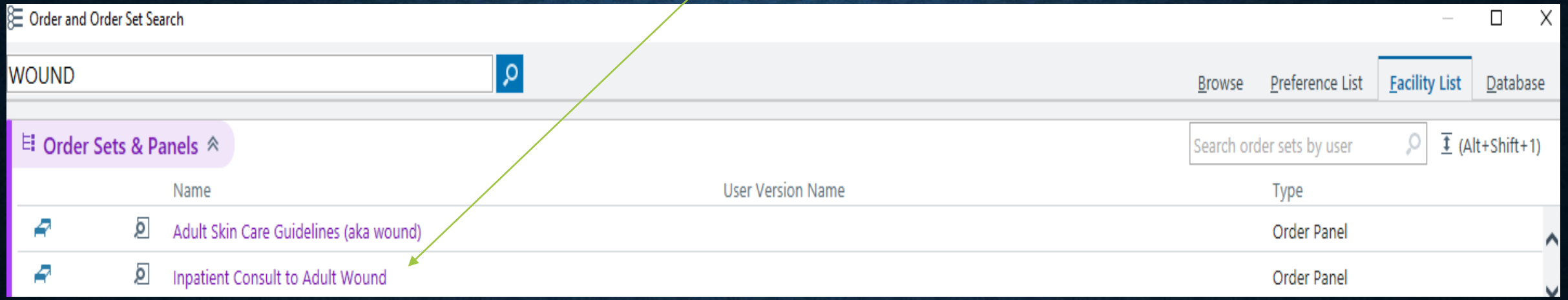
- All wound consults are now directed to the Adult Wound Team.
- Because it is a consult, this order is provider driven and requires a provider to enter the order.
- A nurse may enter the order at the direction of the provider, if the provider is unavailable and has given consent. This would be done as a verbal order with readback and cosigned by the provider.
- If the patient volume exceeds resources, the Adult Wound Team will triage appropriate wounds with a consult order to the WOC Nurse Team.
- In some cases, long term inpatients may also be followed by the WOC Nurse team, at the direction of the Adult Wound Team for follow up.

NURSING IMPACT

- For Skin Tears (uncomplicated), skin fold management, MASD, and Stage 1 or 2 Pressure injuries, Nursing can implement an order for Skin Care Guidelines.
- For patients with a concerning wound, the nurse should upload a picture to the patients EMR and ask the patient's primary team to assess the patient and enter a consult for the Adult Wound Team, if appropriate. Generally, stage 1 and 2 pressure injuries will be managed by nursing, as previously done using the guidelines and do not require consultation.
- The WOC Nurse Team will continue to be consulted for Ostomies, Tubes, and Fistulas. This process has not changed.
- The WOC Nurse Team is available via eStar paging.

ORDERING A WOUND CONSULT

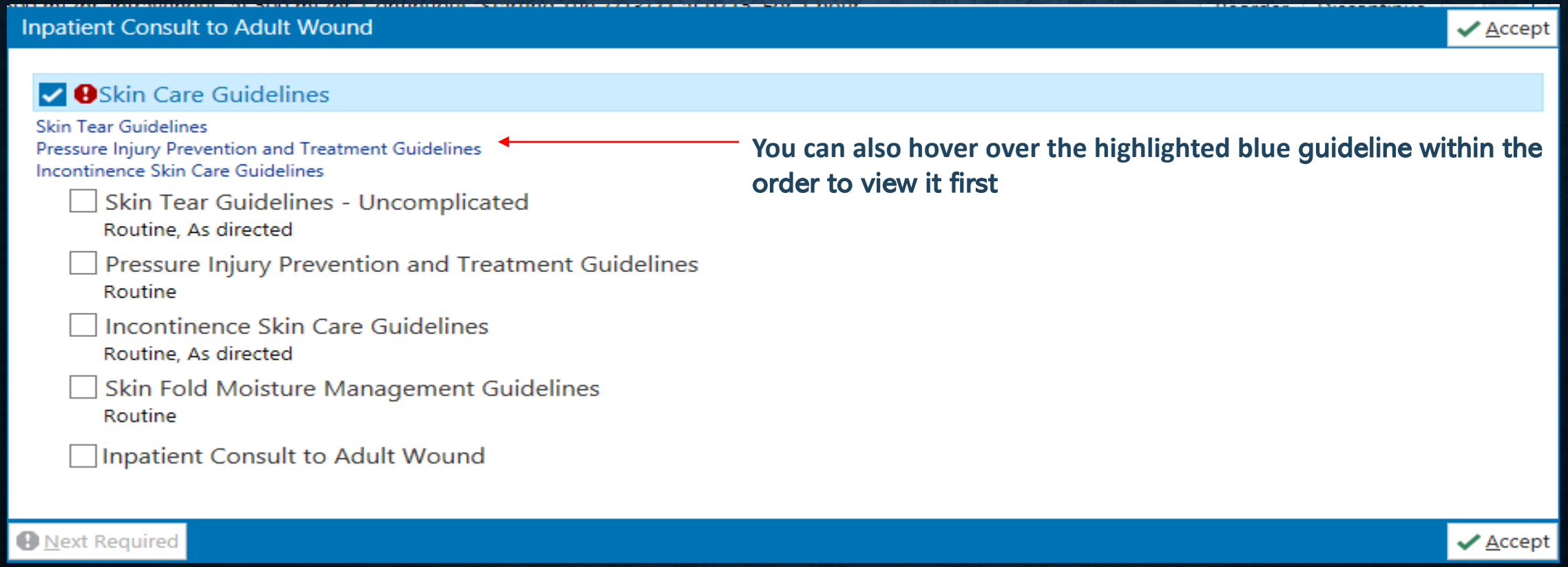
- Go to orders and type in Wound in the search bar.
- A provider order is required for the Inpatient Consult to Adult Wound
- A nurse may enter the order at the direction of the provider, if the provider is unavailable and has given consent. This would be done as a verbal order with readback and cosigned by the provider.



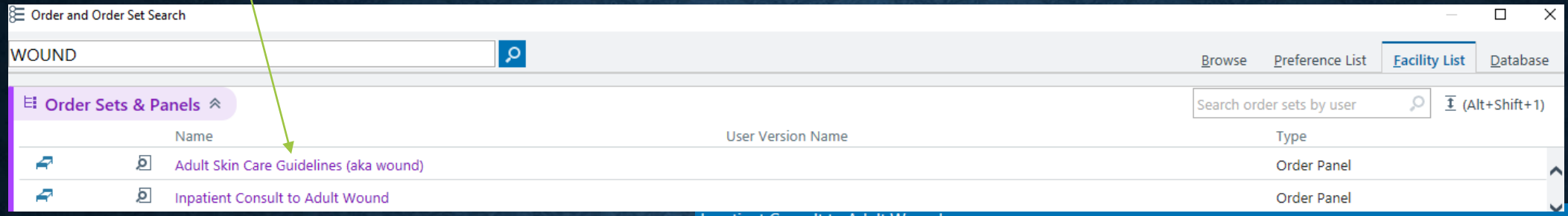
- Consults to Adult Wound are triaged by an Advanced Practice Provider within the Plastic Surgery Service.

Entering Guideline Orders:

- There are various options to choose inside the Skin Care Guidelines:
- The RN selects the Guideline she would like to initiate (Skin Tear, Pressure Injury, Incontinence Skin Care, Skin Fold, etc).
- Or a provider can choose to consult the Adult Wound Team (last selection)

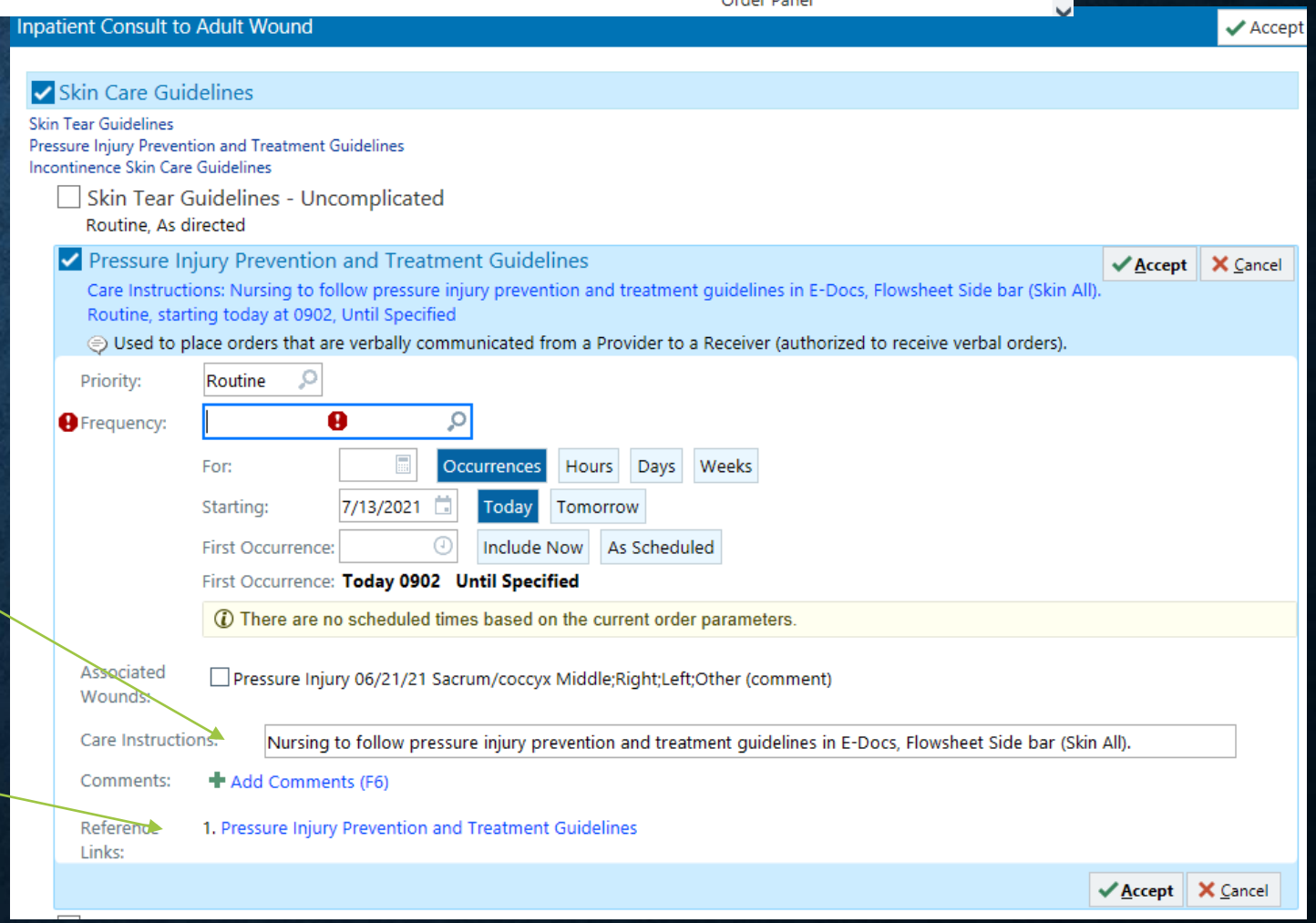


Guideline orders can be entered by a Provider or by an RN (within clinical scope).

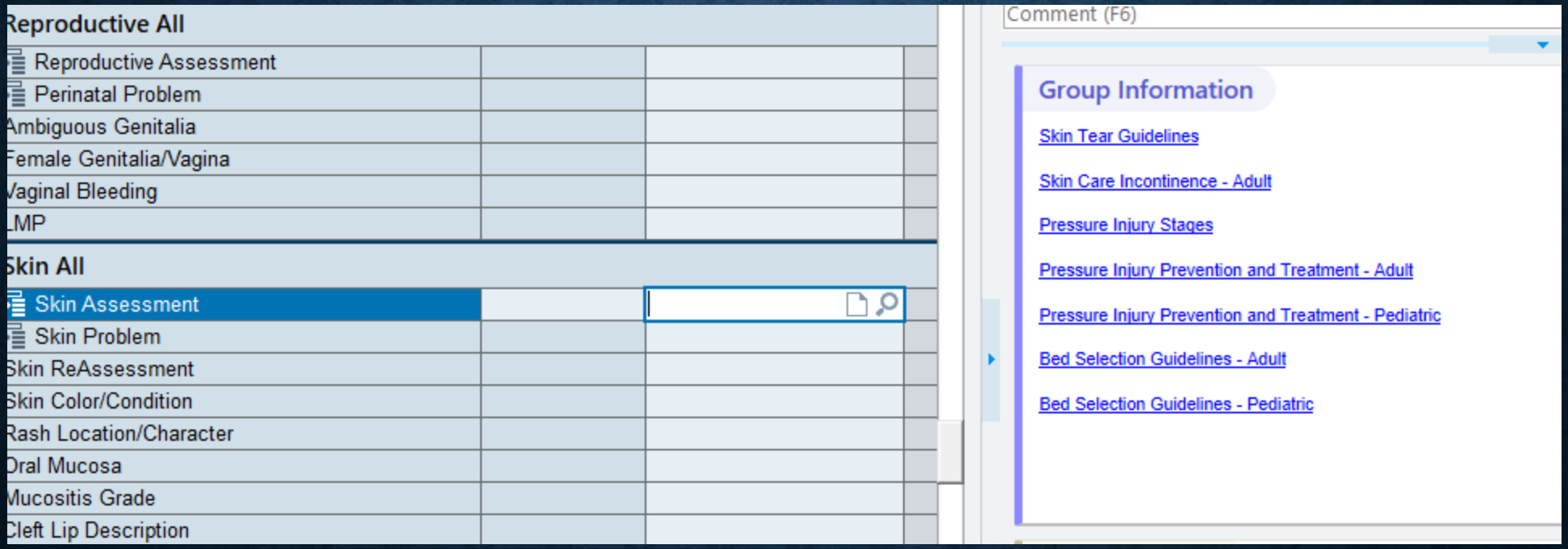


Guideline orders will show up as an order in Estar as well as provide locations where the Guideline exists.

There is also a highlighted link that shows up on the order as well as on the order review.



TO VIEW THE GUIDELINE ORDERS WITHIN EPIC, GO TO “SKIN ALL” AND OPEN THE RIGHT SIDEBAR ARROW. CLICK ON THE LINK TO VIEW THE GUIDELINE.



THE ESTAR LINKS WILL DISPLAY THE GUIDELINE DOCUMENT AS SUCH:

VUAH Pressure Injury (PI) Prevention and Treatment Guidelines

Perform skin assessment and Braden risk scale within 8 hours of admission, every shift, and with significant change in patient condition (i.e., surgery, decline in condition).
"AT RISK" IS 18 OR LESS

PREVENTION GUIDELINES: INITIATE FOR ALL AT RISK PATIENTS AND FOR ANY STAGE PRESSURE INJURY
- Consider pressure redistribution devices: air chair cushion, foam heel boots, foam dressings, bed (see Bed Selection Guidelines)
- Reposition: q2 hours while in bed; KEEP OFF area of pressure injury
- Chair considerations: For patient unable to reposition themselves, reposition at least q1 hour; Consider sitting limitations (2 hours for at risk patient, 1 hour, TID for patient with ischial or sacral PI; Modify/reduce sitting schedule if PI worsens)
- Shear/Friction reduction: Turn & position system, pull/slippery sheets, overbed trapeze, hover mat
- HOB less than or equal to 30 degrees *unless clinically contraindicated*
- Initiate adult urinary & fecal incontinence guidelines

STAGE 1
- ❑ Prevention guidelines
- ❑ Apply foam or Tegaderm absorbent dressing, Change twice a week and prn*

*If dressing must be changed >2x per shift, remove dressing and use barrier cream only

STAGE 2
- ❑ Prevention guidelines
- ❑ Intact blister: DO NOT OPEN OR DRAIN
- ❑ Open stage 2: Cleanse with normal saline, apply foam or Tegaderm absorbent dressing, Change twice a week and prn*

*If dressing must be changed >2x per shift, remove dressing and use barrier cream only

STAGE 3 & DTI
- ❑ Prevention guidelines
- ❑ Cleanse with NS, protect periwound with skin sealant wipe or spray
- ❑ Apply foam dressing; Change twice a week and prn

STAGE 4
- ❑ Prevention guidelines
- ❑ Cleanse with NS, protect periwound with skin sealant wipe or spray
- ❑ Apply dressing: NS moistened kerlix roll gauze, cover w/ ABD pad and secure, change q12h

UNSTAGEABLE
- ❑ Prevention guidelines
- ❑ Apply dry gauze dressing; Change daily

REQUIRED: Notify MD/NP for Adult Wound consult for DTI, stage 3, 4, & unstageable

OTHER:
- Consider consults to Nutrition, PT/OT, Case Management/Social Work
- Provide patient and family education: "Pressure Injury Prevention: Help Us Protect Your Skin" (eDocs), Krames HealthSheets, Mosby's/Elsevier, and/or GetWell Network
- Discharge planning: Wound care supplies and instructions, home health referral, bed and chair devices
- DOCUMENT: Assessment, interventions, education, consults, discharge planning

MC 9803 (04/2021)

Adult Urinary and Fecal Incontinence Guidelines

Incontinent of Urine and/or Solid Stool

SKIN BARRIER PRODUCTS

Use as first line of protection on perineal skin from incontinence related dermatitis

Skin Barrier Options
- Barrier cloth wipes
- Barrier spray
- Critic-Aid cream (dimethicone)

Containment Options
- Condom catheter
- Purewick
- Absorbent underpad
- Indwelling catheter (avoid when possible)
- Disposable brief/diaper (avoid when possible)

Incontinent of Liquid Stool or Diarrhea
(short term management)

SKIN BARRIER PRODUCTS

Use as first line of protection on perineal skin from incontinence related dermatitis

Skin Barrier Options
- Barrier cloth wipes
- Critic-Aid cream (dimethicone)
- Zinc oxide based cream
- ILEX paste

Containment Options
- Absorbent underpad
- Rectal pouch
- Disposable brief/diaper (avoid when possible)

Incontinent of Liquid Stool or Diarrhea
(long term management)

BOWEL MANAGEMENT SYSTEM

Incontinent of high volume or high frequency diarrhea >24 hours
AND
one or more of the following:

- Patient cannot toilet themselves independently (examples: spinal cord injury, too hemodynamically unstable to move, long term immobility, on ventilator)
- Diarrhea due to C. diff infection
- Previous methods of skin protection (barrier creams, rectal pouch) have failed.
- Patient has wounds or grafts that are likely to become contaminated with feces.
- Skin breakdown or at high risk of skin break down (Braden score 18 or less)

VUAH Skin Tear Guidelines

- Cleanse with normal saline. Pat dry.
- Apply 3M Cavilon no-sting barrier spray to periwound skin
- If skin flap present, gently approximate the flap

-AND-

DRY/MINIMAL EXUDATE
Apply **one of the following** options:

Tegaderm Absorbent acrylic dressing
- Change weekly and prn
- If skin flap present, draw arrow on dressing in direction of flap so as to not disturb the flap during dressing removal.

-OR-

Apply **Solosite hydrogel** to wound, then **Mepitel nonadherent dressing**
- Cover with dry gauze
- Secure with roll gauze
- Daily: remove outer dressings and re-apply Solosite hydrogel on top of Mepitel
- Change Mepitel weekly

HEAVY EXUDATE or LARGE AREA

Apply **Mepitel nonadherent dressing**
- Cover with dry gauze or ABD pad
- Secure with roll gauze
- Change **outer** dressings prn saturation (leave Mepitel in place)
- Change Mepitel weekly

PRODUCT PMM NUMBERS
Tegaderm absorbent: #83548 (small oval), #83545 (medium oval), #83546 (large oval), #83547 (4x4" square)
Mepitel: #147744 (4x7"), #62676 (8x12")
Solosite gel: #84935

GENERAL PREVENTION OF SKIN TEARS
- Avoid tape or band-aids when possible
- When tape is required, use paper tape or Medipore; Apply 3M Cavilon no-sting barrier under tape
- Use adhesive remover as needed for adhesive removal
- Moisten dressings with saline before removal if adherent to wound
- Avoid trauma and employ gentle patient handling techniques
- Use gentle skin cleansing techniques and apply moisturizer daily

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