

	Policies and Procedures Title: COMPRESSION BANDAGES- CARE OF I.D. Number: 1038
Authorization: [X] SHR Nursing Practice Committee	Source: Nursing Date Effective: January 25, 2017 Scope: SHR & AFFILIATES

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DEFINITIONS:

Certified Nurse - A nurse that received certification according to the policy for that profession in the application of compression bandaging (See Compression Bandaging – Application of: Policy #1094.

Client – Term used to refer to residents, patients and clients.

Compression Bandages- Bandages made of fabrics that are elastic, inelastic or a combination of the materials that apply a graduated compression to the limb.

Unregulated Care Provider (UCP) - UCPs do not have a regulatory body or a legally defined scope of practice and work under the guidance of a nurse. Refers to but not limited to: Continuing Care Assistant (CCA), Personal Care Assistant (PCA), Home Health Aide, Home Care Aide, Daily Living Attendant, Special Care Aide (SCA), or Care Partner.

Nurse- A Registered Nurse (RN), Registered Psychiatric Nurse (RPN) or Licensed Practical Nurse (LPN) that is not certified in the application of compression bandaging.

1. PURPOSE:

- 1.1 To ensure safe assessment and care for clients with compression bandaging (with 20 mmHg or more compression).

***Note:** This policy does not apply to compression garments (i.e. compression stockings and specialty garments).*

- 1.2 To support the nurse who is not certified in compression bandaging application in order to provide the necessary assessment and care for a client with compression bandages.

2. POLICY:

- 2.1 Compression bandaging can only be applied by a certified nurse.
- 2.2 Care of compression bandages will be done by nurses and/or certified nurses.
- 2.3 Nurses who do not have compression bandaging application certification must report any abnormalities noted in their nursing assessment to a certified nurse.

- 2.4 In Long Term Care (LTC) and Acute Care the assessment of client tolerance to the compression bandaging system will be completed once a shift. In Home Care this is completed at each scheduled client visit.
- 2.5 A client with compression bandaging, who also has complex co-morbidities such as a history of cardiovascular disease (i.e. Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and/or is palliative, will be assessed for signs and symptoms of exacerbation once per shift. The nurse must immediately notify the Most Responsible Physician (MRP)/Registered Nurse (Nurse Practitioner) (RN(NP)) and document on the appropriate nursing record.
- 2.6 The nurse must report all concerns to the certified nurse and/or MRP /RN (NP) or Wound Care Clinician (WCC)/Enterostomal Therapy Nurse (ETN) for further recommendations.
- 2.7 When the nurse is unable to direct their concerns to the most appropriate individual for further recommendations (i.e. after hours or in rural facilities), the client will have the bandages removed as per manufacturer's instructions. Arrangements should be made for the client to be assessed by a certified nurse and rewrapped, if appropriate, as soon as reasonably possible.
- 2.8 The nurse will document findings on the appropriate nursing record according to sector specific policy.

3. PROCEDURE:

3.1 Nurse Role:

- 3.1.1 Inspect compression bandages for:
 - Any strike-through of drainage or other moisture
 - Any client manipulation of the bandages (i.e. pushed down, cutting or slippage).
- 3.1.2 Assess the client for:
 - Pain level
 - Excessive swelling of toes, knee, or upper thigh
 - Increased numbness/tingling of the feet
 - Unusual discoloration
 - Exacerbation adverse signs and symptoms (i.e. sudden shortness of breath, cough, white frothy phlegm, crackles, edema, etc.).
- 3.1.3 Reinforce teaching (see 3.3).
- 3.1.4 Report any abnormal findings of the inspection and assessment to the MRP/RN (NP) and/or certified nurse.
- 3.1.5 An alternative option for compression may be needed when compression is removed for any reason if ordered by the MRP/RN (NP) or recommended by a certified nurse (i.e. tubular bandage).

3.1.6 Document:

- Client tolerance to treatment
- Condition of the compression bandages
- Any abnormal findings and who this was reported to if appropriate.

3.1.7 On discharge/transfer the nurse:

- 3.1.7.1 Ensures that CPAS is notified.
- 3.1.7.2 Obtains a written order from the MRP/RN (NP) that includes the type of compression product, compression strength in mmHg and frequency, to be provided to the community certified nurse.
- 3.1.7.3 3.1.6.3 Ensures that discharge teaching is done and provides the client/caregiver with the Compression Bandage Client Information and Safety Instructions (Appendix A).
- 3.1.7.4 3.1.6.4 Instructs the client/caregiver to call their supporting community agency should they have concerns.

3.2 Unregulated Care Provider (UCP) Role:

3.2.1 Report to nurse:

- Any moisture or soak through of the compression bandaging
- Any client manipulation of the compression bandage (i.e. slippage, cutting, pushing down or partial removal)
- Client concerns of leg pain, numbness/tingling feet, swelling, discoloration of feet, breathing problems or any other concerns.

3.3 Client Teaching

3.3.1 Reinforce to the client (See Appendix A):

- Do Not alter or rewrap your bandage on your own
- Do Not sit or stand in one position for more than 2 hours
- Do Not wear restrictive or tight clothing
- Do Not cross your legs
- Do calf muscle exercises as tolerated (for example, walking, or wiggling toes)
- Do keep the compression bandage dry at all times (i.e. cover with bag during shower)
- Do elevate your legs above the level of your heart throughout the day (minimum 30 minutes 4 times per day) dressing change.

3.3.2 If the following signs and symptoms occur, teach the client to elevate their legs above the heart and take/request analgesic medication:

- Increased lower leg pain
- Numbness and tingling in the feet
- Swelling
- Bandages that feel tighter than usual

Note: *If the symptoms are not resolved by elevation and analgesia, remove the bandages completely and notify the MRP/NP(RN) and/or the WCC/ETN. The timeframe for resolution of the symptoms will be dependent on the type of analgesia used.*

- 3.3.3 Notify the nurse immediately if there is any blueness/whiteness or discoloration of the toes.

Note: Home Care clients should remove the bandages immediately and notify the nurse.

3 REFERENCES:

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Compression Bandage Therapy Client Information & Safety Instructions

Appendix A

What is it? The bandage that has been applied to your leg is called a *compression bandage*. Compression bandaging promotes normal flow of blood and reduces edema (swelling). It is proven to be the most effective treatment for venous leg ulcers, cellulitis, and/or for the reduction of edema. To ensure your treatment is as effective as possible it will be important that your nurse changes the compression bandage regularly. You will require compression garments following compression bandaging therapy. Your nurse will discuss this with you.

It is **normal** for the compression bandage to feel snug when it is applied but it should not be painful. It may also feel snuggier at night during the first few days of treatment. Your Physician or RN (NP) may have prescribed you pain medication.



'Dos and Don'ts' when wearing a compression bandage:

- **Don't** alter or rewrap your bandage on your own
- **Don't** sit or stand in one position for more than 2 hours
- **Don't** wear restrictive or tight clothing
- **Don't** cross your legs
- **Do** calf muscle exercises as tolerated (for example, walking, or wiggling toes)
- **Do** keep the compression bandage dry at all times (i.e. cover with bag during shower)
- **Do** elevate your legs above the level of your heart throughout the day (minimum 30 minutes 4 times per day)

Note for Home Care Clients ONLY:

- The Home Care Nurse may teach you how to remove the compression bandage so you can shower just prior to your scheduled dressing change.

If you experience any of the following symptoms you need to elevate your legs and contact the nurse immediately for further direction:

- Increased pain in your lower leg
- Numbness, tingling, and/or 'pins and needles' in your toes or foot
- Increase in swelling with or without a blue or white discoloration of your toes

Note: The timeframe for resolution of the symptoms will be dependent on the type of pain reliever used.

Note for Home Care Clients ONLY: If the above symptoms are not resolved following elevation of the legs AND taking your pain medication:

- o remove the compression bandage with the special bandage scissors you have been provided and as taught by the Home Care Nurse
- o notify your Home Care Nurse by calling the appropriate number (see page 2 for Home Care Office listings)

Saskatoon Health Region Home Care Office Contact Listings:

Saskatoon Home Care	
Home Care	306-655-4300
Treatment Centre	306-655-4300

Rural Home Care - areas surrounding Saskatoon	
Humboldt/ Watson/ Quill Lake	306-682-2609
Lanigan/ Nokomis/ Watrous/ Strasbourg	306-365-1440
Wakaw/ Rosthern/ Cudworth	306-233-4611
Wynyard/ Wadena	306-338-2517