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|  | Policies and Procedures Title: NEGATIVE PRESSURE WOUND THERAPY RN Specialty Practice: RN Clinical Protocol: Advanced RN Intervention: Negative Pressure Wound Therapy LPN Additional Competency: Negative Pressure Wound Therapy with an Established Plan of Care I.D. Number: 1160 |
| Authorization: [] SHR Nursing Practice Committee | Source: Nursing Date Reaffirmed: May 2017 LPN role updated Date Revised: May 2016 Date Effective: November 2006 Scope: SHR and Affiliates |

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For the purpose of this policy, client will be used when referring to clients, patients and residents.

DEFINITIONS

Enterostomal Therapy Nurse (ET) - A Registered Nurse with advanced and specialized knowledge and clinical skills in wound, ostomy and continence care.

Established Plan of Care – the plan of care for NPWT will be considered established once the initial dressing application is functional and the schedule for dressing changes identified. The NPWT plan of care must be documented in a nursing care plan. If any alteration in dressing materials or application process is required, the plan of care is no longer considered established.

Initiate – For the purpose of this policy, initiate means the initial application of the dressing and NPWT unit.

Negative Pressure Wound Therapy (NPWT) - An integrated wound management system that delivers negative pressure to promote wound healing in a variety of wound types including surgical incision management and wounds healing by secondary intention.

Negative Pressure Wound Therapy with Instillation (NPWTi) – A negative pressure wound therapy system that delivers negative pressure coupled with automated, controlled delivery and removal of topical wound solutions in the wound bed.

Regional Wound Resource Team (RWRT) – Registered Nurses and ETs with advanced and specialized knowledge and clinical skills in wound care, who provide consultation and support collaboration with nurses in acute care for clients who have complex wound care needs.

ROLES

Licensed Practical Nurses (LPNs) – LPNs identified by the manager in targeted practice settings, will be certified in the LPN Additional Competency: Negative Pressure Wound Therapy with an

Established Plan of Care, and may maintain and change NPWT autonomously, as assigned, for clients who are less complex, more predictable and at lower risk for negative outcomes. If a change is required in the NPWT plan of care, the LPN will consult with a certified RN, Wound Resource Nurse or physician and work collaboratively to establish a new plan of care.

In practice settings which are not targeted, LPNs currently educated or certified may continue to provide Negative Pressure Wound Therapy, as assigned, but LPNs requiring initial certification will not be certified until targeting is approved for the practice setting.

Registered Nurses (RNs) - RNs identified by the manager in targeted practice settings, will be certified in this RN Specialty Practice: Advanced RN Intervention of Negative Pressure Wound Therapy.

Registered Psychiatric Nurses (RPNs) – RPN certification for this Speciality Practice is under review by the SHR Nursing Practice Committee. As assigned, currently educated or certified RPNs may continue to provide Negative Pressure Wound Therapy. RPNs requiring initial certification or education will not be certified or educated until the review is complete.

1. PURPOSE

- 1.1 To standardize the management of wounds where NPWT is indicated.
- 1.2 To ensure all clients in SHR receive treatment that is in keeping with best practice guidelines for wound care.
- 1.3 To ensure that certified staff will be able to initiate and/or maintain a NPWT system.

2. POLICY

2.1 Nurses identified by their manager will require certification in this procedure. The certified nurse will have first completed the following activities prior to providing NPWT independently:

- Attended an educational session on NPWT
- Completed the NPWT Learning Module and quiz
- Complete a competency checklist with a certified nurse during a NPWT dressing change on a client
- Provide documentation of learning module quiz and skills checklist to educator/supervisor.

2.2 NPWT/NPWTi utilizing the V.A.C. Uita™ Therapy System is only to be initiated in Acute Care.

Note: *The option of utilizing V.A.C. VeraFlo™ Negative Pressure Wound Therapy with Instillation (NPWTi) should be referred to the Regional Wound Resource team (RWRT) utilizing In-patient Wound Referral form #103620 (Appendix A).*

2.3 The NPWT Prevena Incision Management System is only to be initiated in the OR.

2.4 NPWT utilizing the ActiV.A.C.® or V.A.C.Via™ may be initiated in Acute Care, Long Term Care (LTC) and in Home Care (HC).

2.5 The physician is responsible for writing orders to initiate and maintain NPWT, utilizing the appropriate pre-printed order set

- Negative Pressure Wound Therapy order set #102840 (Appendix B) **or**
- Prevena™ Incision Management System order set #104036 (Appendix C) **or**
- V.A.C. VeraFlo™ Negative Pressure Wound Therapy with Instillation order set #104037 (Appendix D)

2.6 With the exception of NPWT initiated in the OR, NPWT will not be initiated on a weekend or statutory holiday.

- 2.7 Outside of the OR, NPWT will be initiated as per physician's order, by
- A member of the RWRT (urban acute care) **or**
 - Enterostomal Nurse Educator (Community ET; urban HC and LTC) **or**
 - Certified staff as identified by this policy (refer to Roles)

Note: *Complex wounds in acute care should be referred to the RWRT utilizing In-patient Wound Referral form #103620 (Appendix A). Complex wounds in HC and LTC should be referred to the Community ET using Wound Resource Referral form (Appendix E).*

2.8 Following initiation of NPWT certified staff as identified by this policy, will reapply and maintain the therapy system as ordered by the physician.

- 2.9 A complete wound assessment, including wound measurements will be performed prior to the initial application of NPWT and at every dressing change during therapy.
- Complete Wound Care Record (#103527, Appendix F) or the appropriate wound assessment form for your clinical area
 - If taking photographs of the wound, complete the Media Consent Form (Appendices G and H) and have it signed by the client or substitute decision maker

2.10 Sterile technique will be used.

2.11 Personal Protective Equipment will be worn. Complete a Point of Care Risk Assessment (POCRA), to determine PPE appropriate to the procedure being done.

Note: *Refer to Infection Prevention and Control Policy and Procedures: Point of Care Risk Assessment (POCRA) #20-25; Masks, Eye Protection and Face Shields #20-40; Personal Protective Equipment (PPE) - Donning and Doffing #20-150.*

2.12 The NPWT dressing will be changed three times a week or as per physician's order.

2.13 The NPWT dressing will be removed if negative pressure is off for a period exceeding two hours.

- Remove drape and foam
- Irrigate the wound with normal saline or if using silver foam with sterile water
- Reapply NPWT or apply an alternative dressing
- Notify prescribing physician and the RWRT (acute care) or the Community ET (HC and LTC) if NPWT cannot be reapplied.

2.14 The physician will be notified if drainage from the wound fills the NPWT canister in less than 30 minutes.

Note: *A connector is included in every Prevena™ Incision Management System kit that will connect the Prevena™ dressing to an ActiVAC® if the Prevena canister fills too quickly or is not providing sufficient negative pressure.*

- 2.15 Discontinuation of NPWT will be considered when
- The goal of therapy has been met
 - No response or improvement in the wound is observed within two weeks
 - Relative or absolute contraindications are present (Appendix I)
 - The client is unable or declines to follow a concordant plan of care

Notify the prescribing physician, or refer to the RWRT (acute care) or the Community ET (HC and LTC) to reassess the treatment plan. Use In-patient Wound Referral form #103620 (Appendix D). HC and LTC use Wound Resource Referral form (Appendix E).

3. PROCEDURE

3.1 To access NPWT rental machines

- Acute Care units and SHR owned and operated LTC Homes should refer to their ward/facility NPWT binder, or the Skin and Wound Care webpage on the SHR InfoNet.
- HC and Affiliates should follow their own procedures for accessing a NPWT unit.

3.2 To access NPWT consumable supplies

- Saskatoon HC, urban Acute Care and urban SHR owned and operated LTC Homes should access NPWT consumable supplies through Stores at RUH, SCH and SPH.
- Rural HC, rural Acute Care and rural SHR owned and operated LTC Homes will access NPWT consumable supplies through Stores at Humboldt District Health Complex
- Affiliates will access NPWT consumable supplies from the appropriate vendor for their NPWT unit

3.3 Supplies needed

- Appropriate NPWT unit, based on wound assessment and physician's orders
- NPWT dressing kit. Foam type is based on wound assessment and physician's orders
- NPWT canister
 - Canister size will depend on the therapy unit being utilized
 - Canisters should be changed when full or at least every 7 days
- Non-sterile gloves
- Sterile gloves
- Dressing tray
- Sterile scissors (2)
- Skin barrier
- Incision/wound bed contact layer if applicable e.g. meshed silicone dressing
- Sterile water (if silver foam is being used) or normal saline. Size will depend on wound assessment, but should not be less than 2 – 60ml twist top normal saline, or 35 ml syringe and 19 gage blunt needle with at least 100ml sterile saline.
- Protective gown, mask and goggles (if risk of splash from wound is present)
- Waterproof plastic disposable trash bag

3.4 Removal – Prevena Incision Management System™ (PIMS)

3.4.1 Turn off therapy unit immediately prior to dressing change.

3.4.2 Perform hand hygiene. Don non-sterile gloves.

3.4.3 Remove dressing in line with sutures/staples by gently stretching transparent drape horizontally and removing slowly while supporting the exposed skin.

3.4.4 Remove gloves, perform hand hygiene.

Note: *Once removed the PIMS should not be reapplied. Apply an alternative dressing and notify the prescribing physician, or refer to the RWRT (acute care) or the Community ET (HC and LTC) to reassess the treatment plan.*

3.5 Removal – NPWT with ActiV.A.C.® or V.A.C.Ulta™ ; NPWTi with V.A.C.Ulta™

3.5.1 Administer analgesia if required, as ordered, prior to dressing change.

3.5.2 Thirty minutes prior to dressing change, turn off therapy unit and close tubing clamps.

Note: *For incision management dressing changes turn off therapy unit immediately prior to dressing change.*

3.5.3 Prior to removing the dressing, check the Wound Care Record (#103527, Appendix F) or appropriate wound assessment form for your clinical area, for the type and quantity of each dressing material used for the last dressing change. This includes foam and wound contact dressing layers.

3.5.4 Perform hand hygiene and prepare dressing removal supplies. Don PPE and non-sterile gloves.

3.5.5 Instillation of normal saline/sterile water into the foam may facilitate atraumatic removal

- Cut several small openings in transparent drape where it covers foam
- Using a 35 ml syringe with a 19 gauge blunt needle instil generous amounts of warm, sterile saline/water through each opening
- Wait 15-30 minutes before removing dressing

3.5.6 Remove transparent drape by gently stretching horizontally and removing slowly while supporting the exposed skin.

Note: *Incision management dressings should be removed in line with the sutures/staples*

3.5.7 Support tissues and surrounding skin when removing foam.

3.5.8 Confirm that the number and type of foam pieces and wound contact layer removed from the wound corresponds to that documented for the previous dressing change.

3.5.9 Remove gloves, perform hand hygiene.

3.6 Application – NPWT/NPWTi

3.6.1 Don non-sterile gloves.

3.6.2 Cleanse the wound/incision as per Wound Irrigation and Packing policy #1030.

3.6.3 Remove gloves, perform hand hygiene.

3.6.4 Set-up dressing supplies.

3.6.5 Don sterile gloves.

| NPWT with ActiV.A.C.® or V.A.C.Ultra™ | NPWTi with V.A.C.Ultra™ | NPWT Incision management with ActiV.A.C.® |
|---|---|---|
| Apply wound contact layer, if required, to wound bed | Apply wound contact layer, if required, to wound bed | Apply contact layer over incision |
| Cut Granufoam to dimensions that will allow the foam to be placed in the wound without overlapping onto intact skin, and at a height that will allow the dressing to be flush or slightly higher than the periwound once vacuum has been applied. | Cut VAC VeraFlo™ dressing to dimensions that will allow the dressing to be placed in the wound without overlapping onto intact skin, and at a height that will allow the dressing to be flush or slightly higher than the periwound once vacuum has been applied. | Cut Granufoam so that it is double the width of the incision. |

- 3.6.6 Apply skin barrier and transparent drape to periwound skin as needed.
- 3.6.7 Cut a piece of drape large enough to cover the foam plus an additional 3-5cm of intact periwound skin, without stretching the drape. Place over wound/incision to obtain an occlusive seal.
- 3.6.8 Pinch transparent drape and cut a hole at least 2.5cm diameter through the drape over centre of foam.
- 3.6.9 Remove backing from TRAC™ pad. Place pad opening in central disc directly over hole in drape. Consider which way the tubing will lay to prevent interference with client mobility and to avoid risk of pressure related skin damage. Apply gentle pressure to ensure adhesion. Remove blue tab.
- 3.6.10 Insert canister into therapy unit until it locks into place.
- 3.6.11 Connect canister tubing to TRAC™ pad tubing. Open clamps.
- 3.6.12 Turn on power to therapy unit and select prescribed therapy settings.
- 3.6.13 Check dressing to ensure a good seal.
- 3.6.14 Secure tubing
 - Cut a strip of transparent drape
 - Place around tubing and press together between dressing and tubing before anchoring it to the transparent drape cover dressing
- 3.6.15 Write the date and number of pieces and type of dressing materials used on the transparent drape using a permanent black marker pen.

3.7 Documentation

- 3.7.1 Record application of NPWT on Wound Care Record (#103527) or the appropriate wound assessment form for your clinical area. Include:
 - Measurements (length, width and depth)
 - Undermining or tunnelling, noting location and size
 - Evidence of bone or tendon exposure

- Appearance of wound bed, noting percentage of tissue types
- Amount and type of exudate, if present
- Presence of odor, after cleansing
- Appearance of wound edge and periwound skin
- Type and number of foam pieces removed/inserted/applied
- Type and number of any other dressing materials used
- Client tolerance

3.8 Monitoring and Care during Therapy

3.8.1 The dressing should be visually checked every two hours to ensure

- The foam is firm and collapsed
- The display screen indicates that the therapy unit is active
- Clamps are open and the tubing is not kinked
- The canister is not full

Note: If the NPWT system is not operating effectively, refer to manufacturer's clinical guidelines for troubleshooting solutions or contact the vendor's local clinical representative.

3.8.2 The physician will be informed immediately if

- Drainage from the wound fills the canister in less than 30 minutes
- Frank blood or bowel contents is observed in tubing and/or canister
- There is evidence of wound deterioration

3.9 Client Discharge or Transfer between Care Providers

3.9.1 Provide discharge teaching to clients referred to Saskatoon HC or rural HC utilizing "Discharge Instructions for Patients with Negative Pressure Wound Therapy" (#102847).

3.9.2 To facilitate transfer of care

- CPAS/Client Case Coordinator should be notified when NPWT has been initiated **and** the client will be discharged or transferred to another care provider e.g. from Acute Care to HC or between HC and LTC
- Initiate communication between transferring and receiving care providers to ensure NPWT can be maintained and a process is in place to obtain supplies
- Redirect billing for rental NPWT units. Call 1-800-668-5403 or e-mail kciorders@kci1.com
- Document where the rental therapy unit was sent on Tracking of Rental VACs form.

Note: Not all health regions in Saskatchewan use the KCI NPWT rental program. This should be clarified before the therapy unit leaves SHR.

3.9.3 The following information should be communicated prior to and when transferring a client between care providers outside of Saskatoon's acute care hospitals

- Copy of completed physician's orders appropriate to the NPWT modality being used
- Copy of Wound Care Record (#103527) **or** the appropriate wound assessment form for your clinical area, **or** documentation of most recent NPWT dressing change
- List of supplies required (including foam dressing kit size)
- Arrangements for physician/RN(NP) follow up

Note: To prevent any interruption in NPWT, it is required that NPWT dressing supplies are sent with clients going to LTC or rural areas. This should be discussed with the receiving care provider.

- 3.9.4 Clients being transferred to Saskatoon HC or rural HC should have the rental therapy unit changed to a HC owned unit prior to discharge whenever possible. CPAS will
- Alert HC with an estimated discharge date
 - Provide HC with client's name, HSN, location in acute care
 - Confirm date and time client is to be discharged
 - Send completed NPWT pre-printed order set appropriate to the therapy being utilised

A HC unit will be couriered to the acute care site and ward.

Note: If a HC owned unit is not available, HC will require the serial number of the rental unit being sent with the client.

- 3.9.5 Clients with HC owned therapy units who are admitted to acute care will have the HC unit replaced with a rental unit.
- Call HC to alert them to the client's admission
 - In Saskatoon send the HC unit by courier to 310 Idylwyld Drive North
 - Rural HC will arrange for the therapy unit to be collected from a rural acute care facility

3.10 Cleaning and returning NPWT units

- Acute Care units and SHR owned and operated LTC Homes should refer to their ward/facility NPWT binder or the Skin and Wound Care webpage on the SHR InfoNet
- HC should follow their own procedures for returning and cleaning HC owned NPWT units
- Affiliates should refer to the appropriate manufacturer's instructions for cleaning and maintenance of NPWT units

3.11 Disposal of NPWT consumable supplies

- Acute Care units, HC and SHR owned and operated LTC Homes should refer to their ward/facility NPWT binder or the Skin and Wound Care webpage on the SHR InfoNet
- Affiliates should refer to the appropriate manufacturer's current guidelines for disposal

4. REFERENCES

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KCI Licensing Inc. (2014). *V.A.C. Therapy Clinical Guidelines 2-B-128-CA-EN Rev B 12/2014*. Retrieved from <http://www.kci-medical.ca>

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Addressograph

**Regional Wound Resource Team
In-Patient Wound Referral**

Phone 655-4472 Fax 655-4400
Please complete form and fax to 4400

Form **MUST** be completed and faxed as directed to initiate the consultation process.
PHONE CONSULTS ARE NOT ACCEPTED.

DD/MM/YY _____ Referral Initiated by _____

RUH SPH SCH

Unit _____ Room # _____ Unit Phone # _____

Date of Hospital Admission _____ Physician/Surgeon _____

Diagnosis/ Comorbidities _____

Reason For Referral: (Basic Assessment & Wound Care Should be Initiated Prior to Referral)

Wound Location _____ Wound Duration _____

Current Wound Treatment _____


Etiology

- Lower Leg Wounds
- Diabetic Foot Ulcer (DFU)
- Wound Infection
- Cellulitis
- NPWT (VAC)
- Compression Therapy
- Complex Moisture Associated Skin Damage (MASD)
- Palliative
- Non-Healing Pressure Ulcer (Complex only)
 - Stage III Stage IV Unstageable
- Surgical Wound (Surgery date and type) _____
- Other _____


Regional Wound Resource Team (Acute care)
Rhonda Darbyshire RN IIWCC
Carolyn Morin RN BSN ET
306-655-4472

Word Form # 103620 04/14 Category: Referrals/Results


Appendix B

| | | |
|--|---|----------------------|
|  | PATIENT IDENTIFICATION <input type="checkbox"/> RUH <input type="checkbox"/> SCH <input type="checkbox"/> SPH <input type="checkbox"/> OTHER: _____ | |
| Negative Pressure Wound Therapy (NPWT) Order Set | | ACTION |
| | | MAR ICP REC RN |
| *** NPWT will not be initiated on a week-end or stat holiday except in the operating room*** | | |
| <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <p>Consults</p> <p> <input type="checkbox"/> Wound Resource Team : - Reason: _____ <input type="checkbox"/> Dietitian - Reason: _____ <input type="checkbox"/> OT - Reason: _____ <input type="checkbox"/> PT - Reason: _____ <input type="checkbox"/> CPAS - Reason: _____ <input type="checkbox"/> Other _____, - Reason: _____ </p> </div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <p>Wound Type</p> <p> <input type="checkbox"/> Surgical Wound <input type="checkbox"/> Traumatic wound <input type="checkbox"/> Other _____ <input type="checkbox"/> Pressure Ulcer <input type="checkbox"/> Clean, closed surgical incision <input type="checkbox"/> Diabetic Foot Ulcer <input type="checkbox"/> Post Split Thickness Skin Graft (STSG) </p> </div> <p>Wound Location: _____</p> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <p>Treatment Parameters</p> <p> Type of V.A.C.®: <input type="checkbox"/> V.A.C.Ulta <input type="checkbox"/> Acti V.A.C. <input type="checkbox"/> V.A.C.Via Serial # of unit: _____ </p> <p> Goals of Therapy: <input type="checkbox"/> Wound closure <input type="checkbox"/> Prep for surgical closure or graft/flap <input type="checkbox"/> Post STSG <input type="checkbox"/> Other </p> <p> Type of Granufoam: <input type="checkbox"/> Black <input type="checkbox"/> Silver <input type="checkbox"/> White </p> <p> Non-Adherent Layer: <input type="checkbox"/> _____ used over exposed tendon, bone and to decrease pain when removing foam </p> <p> Pressure setting: <input type="checkbox"/> Continuous therapy at 125 mmHg <input type="checkbox"/> Continuous therapy at _____mmHg <input type="checkbox"/> Intermittent therapy at _____mmHg (standard 5 minutes on, 2 minutes off) <input type="checkbox"/> Post STSG 75 mmHg continuous for 5 days </p> <p> Dressing Change Frequency: <input type="checkbox"/> Monday, Wednesday, Friday OR <input type="checkbox"/> _____ <input type="checkbox"/> Post STSG remove post-op on _____ by (surgeon) </p> <p> <input checked="" type="checkbox"/> If NPWT system is off for a period exceeding 2 hours, remove foam and apply an alternative dressing <input checked="" type="checkbox"/> Notify prescribing physician to re-evaluate use <input checked="" type="checkbox"/> If required, pre-medicate with analgesic prior to dressing change. Refer to current analgesia order. Consideration must be given to when the last dose of analgesic was given. </p> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <p>Contact Physician immediately if:</p> <p> <input checked="" type="checkbox"/> Drainage from wound fills canister in less than 30 minutes <input checked="" type="checkbox"/> Frank blood or bowel contents is observed in tubing and/or canister <input checked="" type="checkbox"/> There is evidence of wound deterioration (e.g. erythema, increased exudate, pain) </p> </div> </div> | | |
| FRACTITIONER PRINTED NAME _____ | FRACTITIONER SIGNATURE _____ | DATE/TIME _____ |
| Notice of confidentiality: Contains information that is time sensitive or confidential. Use, disclosure, copying or communication of the contents is prohibited. If you have received in error, notify the SHR Pharmacy Manager, Operations (306-566-6695). | | |
| Form #102840 | 08/15 | Category: Orders |
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Appendix C

| | | |
|---|---|-------------------------|
|  | PATIENT IDENTIFICATION <input type="checkbox"/> RUH <input type="checkbox"/> SCH <input type="checkbox"/> SPH <input type="checkbox"/> OTHER: _____ | |
| Prevena™ Incision Management System Order Set | | ACTION |
| | | MAR ICP REQ RN |
| ***Prevena™ Incision Management System is only to be applied in the operating room*** | | |
| Consults <input type="checkbox"/> Wound Resource Team - Reason: _____ <input type="checkbox"/> Dietitian- Reason: _____ <input type="checkbox"/> CPAS - Reason: _____ <input type="checkbox"/> Other _____ - Reason _____ | | |
| Wound Type <input type="checkbox"/> Clean, closed surgical incision Wound Location: _____ | | |
| Treatment Parameters Type of V.A.C™: <input checked="" type="checkbox"/> Prevena™ Goals of Therapy: <input checked="" type="checkbox"/> Wound closure Pressure setting: <input checked="" type="checkbox"/> Default setting 125 mmHg continuous therapy Dressing Removal: <input checked="" type="checkbox"/> Remove Prevena™ Incision Management System 7 days post application on _____ (date) OR <input type="checkbox"/> _____ <input checked="" type="checkbox"/> If the Prevena™ Incision Management System is off for a period exceeding 2 hours notify prescribing physician to re-evaluate use <input checked="" type="checkbox"/> If the Prevena™ Incision Management System canister fills during therapy notify prescribing physician to re-evaluate use | | |
| Contact Physician immediately if: <input checked="" type="checkbox"/> Drainage from wound fills canister in less than 30 minutes <input checked="" type="checkbox"/> Obtain order to switch device to ActiV.A.C.™ <input checked="" type="checkbox"/> Frank blood or bowel contents is observed in tubing and/or canister <input checked="" type="checkbox"/> Unable to maintain seal <input checked="" type="checkbox"/> There is evidence of wound infection (e.g. purulent exudate, surrounding cellulitis) | | |
| _____ PRACTITIONER PRINTED NAME | _____ PRACTITIONER SIGNATURE | _____ DATE/TIME |
| Notice of confidentiality: Contains information that is time sensitive or confidential. Use, disclosure, copying or communication of the contents is prohibited. If you have received in error, notify the SHR Pharmacy Manager, Operations (306-555-6605). | | |
| Form #104036 | 01/16 | Category: Orders |
| Page 1 of 1 | | |

Appendix D



PATIENT IDENTIFICATION

RUH SCH SPH
 OTHER: _____

| V.A.C. VeraFlo™ Negative Pressure Wound Therapy with Instillation (NPWTi) Order Set | | ACTION | | | |
|--|-----|---------------------------------|--|--------------------|--|
| MAR | ICP | REQ | | | |
| ***NPWTi will not be initiated on a week-end or stat holiday except in the operating room*** | | | | | |
| <p>Consults</p> <p> <input type="checkbox"/> Regional Wound Resource Team - Reason: _____ <input type="checkbox"/> Dietician - Reason: _____ <input type="checkbox"/> PT - Reason: _____ <input type="checkbox"/> OT - Reason: _____ <input type="checkbox"/> Other _____ -Reason: _____ </p> | | | | | |
| <p>Wound Type</p> <p> <input type="checkbox"/> Surgical Wound <input type="checkbox"/> Traumatic wound <input type="checkbox"/> Other _____ <input type="checkbox"/> Pressure Ulcer <input type="checkbox"/> Diabetic Foot Ulcer </p> <p>Wound Location: _____</p> | | | | | |
| <p>Treatment Parameters</p> <p>Serial # of unit: _____</p> <p>Goals of Therapy:</p> <p><input type="checkbox"/> Prep for surgical closure <input type="checkbox"/> Other _____</p> <p>Type of Dressing:</p> <p><input type="checkbox"/> V.A.C. VeraFlo™ <input type="checkbox"/> V.A.C. VeraFlo Cleanse™</p> <p>Interface Layer:</p> <p><input type="checkbox"/> Mepitel One <input type="checkbox"/> Other _____</p> <p>Irrigation Solution:</p> <p><input type="checkbox"/> 0.9% NaCl <input type="checkbox"/> Prontosan™ <input type="checkbox"/> Other _____</p> <p>Solution Soak Time:</p> <p><input type="checkbox"/> 1 minute <input type="checkbox"/> 2 minutes <input type="checkbox"/> 10 minutes</p> <p>Irrigation Frequency:</p> <p><input type="checkbox"/> q1h <input type="checkbox"/> q2h <input type="checkbox"/> q3.5h <input type="checkbox"/> Other q _____ hours</p> <p>Pressure setting:</p> <p><input type="checkbox"/> Continuous therapy at 125 mmHg OR <input type="checkbox"/> Continuous therapy at _____ mmHg</p> <p>Dressing Change Frequency:</p> <p><input type="checkbox"/> Monday, Wednesday, Friday OR <input type="checkbox"/> _____</p> <p> <input checked="" type="checkbox"/> If NPWTi system is off for a period exceeding 2 hours, remove foam and apply an alternative dressing <input checked="" type="checkbox"/> Notify prescribing physician to re-evaluate use <input checked="" type="checkbox"/> Pre-medicate with analgesic prior to dressing change, if required. Refer to current analgesia order. Consideration must be given to when the last dose of analgesic was given. </p> | | | | | |
| <p>Contact Physician immediately if:</p> <p> <input checked="" type="checkbox"/> Drainage from wound fills canister in less than 30 minutes <input checked="" type="checkbox"/> Frank blood or bowel contents is observed in tubing and/or canister <input checked="" type="checkbox"/> There is evidence of wound deterioration (e.g. erythema, increased exudate, pain) </p> | | | | | |
| _____ PRACTITIONER PRINTED NAME | | _____ PRACTITIONER SIGNATURE | | _____ DATE/TIME | |
| Notice of confidentiality: Contains information that is time sensitive or confidential. Use, disclosure, copying or communication of the contents is prohibited. If you have received in error, notify the SHR Pharmacy Manager, Operations (306-655-6695). | | | | | |
| Form #104037 | | 01/18 | | Category: Orders | |

Appendix E



Wound Resource Referral
(Home Care, Community & LTC)
Please complete form and fax to 655-4400

Date: _____

Referred by: _____

Contact #: _____

Clients Name and Location : _____

Diagnosis: _____

Comorbidities: _____

Reason for Referral

- Diabetic Foot Ulcer
- Lower Leg Ulcer
- Pressure Ulcer - Stage: _____
- Burns
- Surgical
- Trauma
- Fistula
- Lymphedema

- Ostomy - Type: _____
- Insitu Tubes – Type: _____
- Incontinence
- ABPI's (complete lower limb assessment form)
- Compression Therapy (Needs Dr. Orders)
- Wound Infection
- Other: _____

Wound Location: _____

History: _____

Contributing Factors: _____

Expected Outcomes: _____

Current and Past Treatments: _____

Psychological Issues: _____

Interdisciplinary Involvement: _____

Urgency for Referral: 1-3 days 1 Week 2-4 week No Urgency

Comments: _____

Holly-Anne Cook- Laliberte, RN, BSN, ETN
Phone: 306-655-4495
December 2013

Appendix F



RUH SCH SPH

Other _____

Addressograph / Label

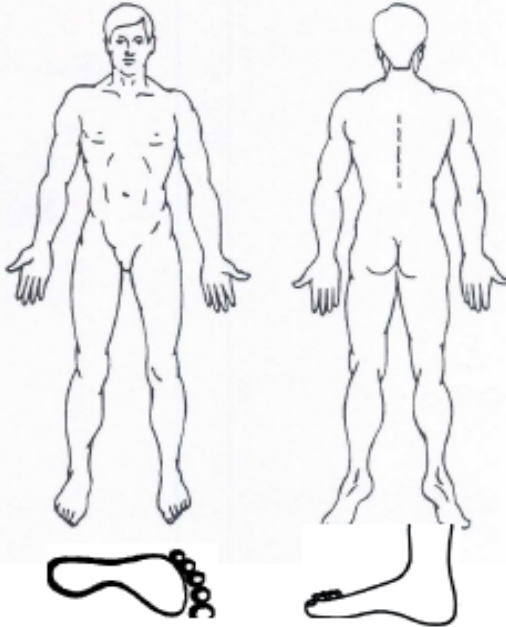
NAME: _____

HSN: _____

D.O.B.: _____

WOUND CARE RECORD

Page 1 of 2



One Wound per Sheet

Admission date _____
 Wound date _____
 Type/origin of wound:
 Burn Skin tear Blister
 Lower limb: Venous Arterial Mixed Diabetic
 Surgical
 Pressure ulcer Stage # _____ at initiation of treatment

| | |
|--------------------|--|
| Deep Tissue Injury | Purple or maroon localized area of discoloured intact skin or blood filled blister |
| Stage 1 | Intact skin. Non-blanching reddened area |
| Stage 2 | Blister or superficial ulcer |
| Stage 3 | Ulcer exposing subcutaneous tissue, presents as a crater |
| Stage 4 | Ulcer exposing muscle and/or bone |
| Unstageable | Black eschar or slough covering base. Cannot determine depth |

Braden score _____ Date and time completed _____
 Speciality surface
 Type and date initiated _____

Consults
 OT PT Dietician Wound Resource Team


Goal
 Healing Palliative/Maintenance

| | | | | |
|---|---|-----------------------------------|---|-------------------|
| Wound Location | | | | |
| Date & Time of Dressing Change | | | | |
| Pain pre dressing | (min)0 1 2 3 4 5 6 7 8 9 10 (max) | (min)0 1 2 3 4 5 6 7 8 9 10 (max) | | |
| Pain mid dressing | (min)0 1 2 3 4 5 6 7 8 9 10 (max) | (min)0 1 2 3 4 5 6 7 8 9 10 (max) | | |
| Pain post dressing | (min)0 1 2 3 4 5 6 7 8 9 10 (max) | (min)0 1 2 3 4 5 6 7 8 9 10 (max) | | |
| Swab taken (After cleansing) | <input type="checkbox"/> N/A <input type="checkbox"/> Yes, Type _____ | | <input type="checkbox"/> N/A <input type="checkbox"/> Yes, Type _____ | |
| Picture taken | <input type="checkbox"/> N/A <input type="checkbox"/> Yes | | <input type="checkbox"/> N/A <input type="checkbox"/> Yes | |
| Soiled Dressing/Packing Removal | | | | |
| Contact & Cover Dressing Removed (Quantity & type) | _____ of _____ | _____ of _____ | _____ of _____ | _____ of _____ |
| Amount of Packing Removed | Type _____ | Length _____ cm | Type _____ | Length _____ cm |
| Negative Pressure Wound Therapy Foam Removed | Type _____ | # of Pieces _____ | Type _____ | # of Pieces _____ |

Word Form # 103527 04/13 Category: Flow Sheets

Appendix G

Media Consent Form for photos that will be emailed to a non-Saskatoon Health Region email address



Media Consent Form

By signing this I give my consent for
[please check one or both]

myself and/or
 my child or dependent.
named: [name of child or dependent]

(PRINT name clearly)

to be;

- interviewed
- photographed
- video/audio taped
- or otherwise recorded

on;

[date the recording takes place]

at;

[location where the recording takes place]

and for the information obtained to be used in any form (e.g. print, electronic, web), for the purposes of, but not limited to:

- publicity or news
- promotion
- education
- research

I understand that Health Region staff, when necessary for the recording process, will be present when and where health services are provided.

By signing this I waive any ownership rights to material obtained; and release the Saskatoon Regional Health Authority and its employees, officers, directors, agents, successors and assignees from all claims, demands, damages or actions or causes of action of any nature whatsoever, arising or to arise from the use of any aforementioned interviews, photographs, videos or audio recordings.

Signature below should be that of the subject or, in the case of a minor, the parent or guardian in law or fact, unless the minor is a "mature minor." For the purpose of consent, any minor who is mature enough to understand the nature and consequences of a decision can consent.

[signature]

(PRINT name – if signature is from parent or guardian)

_____ _____

[date signed] [telephone]

e-mail _____

Witness

Signature below should be that of a witness — to be signed by staff member of the Health Region or Region-affiliated agency.

[witness signature]

(PRINT witness name clearly)

_____ _____

[date signed] [telephone]

Internal Use Photos become part of the medical file. Photos may be used for consultation

Project details: purposes within Saskatoon Health Region (SHR). Consultation via Email may also
be externally used to _____ via _____
the Email address: _____@_____. The "Patient Email
Communications Question & Answer Fact Sheet" was reviewed. (SHR - April 2012)


Source: Communications

Healthiest people – Healthiest communities – Exceptional service

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Appendix H



Media Consent Form

By signing this I give my consent for
 [please check one or both]

myself and/or
 my child or dependent,
 named: [name of child or dependent]

(PRINT name clearly)

to be:

- interviewed
- photographed
- video/audio taped
- or otherwise recorded

on:

[date the recording takes place]

at:

[location where the recording takes place]

and for the information obtained to be used in any form (e.g. print, electronic, web), for the purposes of, but not limited to:

- publicity or news
- promotion
- education
- research

I understand that Health Region staff, when necessary for the recording process, will be present when and where health services are provided.

By signing this I waive any ownership rights to material obtained; and release the Saskatoon Regional Health Authority and its employees, officers, directors, agents, successors and assignees from all claims, demands, damages or actions or causes of action of any nature whatsoever, arising or to arise from the use of any aforementioned interviews, photographs, videos or audio recordings.

Signature below should be that of the subject or, in the case of a minor, the parent or guardian in law or fact, unless the minor is a "mature minor." For the purpose of consent, any minor who is mature enough to understand the nature and consequences of a decision can consent.

[signature]

(PRINT name – if signature is from parent or guardian)

[date signed] [telephone]

e-mail _____

Witness

Signature below should be that of a witness — to be signed by staff member of the Health Region or Region-affiliated agency.

[witness signature]

(PRINT witness name clearly)

[date signed] [telephone]

Internal Use

Project details: _____

Photos become part of the medical file. Photos may be used for consultation, educational, or research purposes. (Saskatoon Health Region - April 2012)

Source: Communications

Healthiest people – Healthiest communities – Exceptional service

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Media Consent Form for photos that will be emailed within Saskatoon Health Region

Appendix I

Is the Wound Appropriate for Negative Pressure Wound Therapy?

