Policies and Procedures

Title: NEGATIVE PRESSURE WOUND THERAPY (NPWT) - APPLICATION AND CARE

RN Specialty Practice (RNSP): RN Clinical Protocol: Advanced RN Intervention
Negative Pressure Wound Therapy
LPN Additional Competency (LPNAC)
Negative Pressure Wound Therapy with an Established Plan of Care
LPN, RN and RPN Entry Level Competency
Monitor NPWT and Remove Dressing

I.D. Number: 1160

Authorization: [X ] Former SktnHR Nursing Practice Committee
Source: Nursing
Date Revised: May 2018
Date Effective: November 2006
Scope: SktnHR and Affiliates

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

DEFINITIONS

Complex wound – For the purpose of this policy, a complex wound is defined as a wound that has not progressed as expected through the healing trajectory. This may be related to one or more etiologies, such as trauma, surgery, sustained pressure, vascular disease, infection, and/or the client has comorbidities that impair normal wound healing. Examples include, but are not limited to:

- a wound that shows signs of delayed healing
- diabetic foot ulcer
- a wound with an abscess or fistula present
- the cause of the wound or the reason for failure to heal is unknown

Enterostomal Therapy Nurse (ETN) - A Registered Nurse with advanced and specialized knowledge and clinical skills in wound, ostomy and continence care. An ETN provides consultation and support, and collaborates with nurses for clients who have complex wound care and/or ostomy care needs.

Established Plan of Care – the plan of care for NPWT will be considered established once the wound has been determined as stable and 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.

Maintain – For the purpose of this policy, maintain means to monitor the NPWT system as per current clinical guidelines and remove and reapply the dressing as ordered by the physician.

Monitor - For the purpose of this policy, monitor means to visually check the dressing and NPWT system as per current clinical guidelines, to ensure the system is operating effectively and there is no evidence of wound deterioration.

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.

Ostomy and Wound Resource Team (OWRT) – Registered Nurses, ETNs, and Registered Nurses with IIWCC (International Interprofessional Wound Care Course). The team has advanced and specialized knowledge and clinical skills in wound, ostomy and continence care. They provide consultation and support, and collaborate with nurses in acute care for clients who have complex wound care and/or ostomy care needs.

Stable – For the purpose of this policy, stable means the condition of the wound is not expected to deteriorate.

T.R.A.C.™ pad – A proprietary technology that maintains and adjusts to deliver set pressure at the wound site.

ROLES

Licensed Practical Nurses (LPNs) – LPNs identified by the manager in targeted practice settings, will be certified in the LPNAC: Negative Pressure Wound Therapy with an Established Plan of Care, and may maintain 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.

Registered Nurses (RNs) – RNs identified by the manager in targeted practice settings, will be certified in this RNSP: Advanced RN Intervention: Negative Pressure Wound Therapy. If a change is required to an established plan of care within an LPN’s assignment, an RN will provide consultation as needed and work collaboratively with the LPN until a new plan of care is established. At any time, if care needs are beyond the individual competence of a certified RN, she will consult and work collaboratively with another certified RN, Wound Resource Nurse or physician.

Registered Psychiatric Nurses (RPNs) – RPN certification for this speciality practice is under review by the former SktnHR 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.

Uncertified LPNs, RNs and RPNs may monitor the NPWT system during therapy and may remove the dressing if negative pressure is off for a period exceeding two hours, and a certified nurse is not available to remove and replace the NPWT system.
1. **PURPOSE**
   - To standardize the management of wounds where Negative Pressure Wound Therapy is indicated.
   - To ensure all clients receive treatment that is in keeping with best practice guidelines for wound care.

2. **POLICY**
   - The RN or LPN certified in this RNSP/LPNAC will have first completed the following learning modules/activities prior to performing NPWT:
     2.1 Complete the required learning module and quiz (teaching and learning methods may vary e.g. classroom and/or self-study using paper module or e-learning).
     2.2 Complete a skills checklist with a certified RN or LPN during simulation or during first application, to ensure safety checks are followed appropriately.
     2.3 Provide documentation of learning module quiz and skills checklist to educator/supervisor.
   - Negative Pressure Wound Therapy with Instillation (NPWTi) is only to be initiated in the Operating Room (OR), or by the Ostomy and Wound Resource team (OWRT).
     **Note:** The option of utilizing NPWTi should be referred to the OWRT utilizing In-patient Wound Referral form #103620.
   - The NPWT Incision Management System is only to be initiated in the OR.
   - NPWT may be initiated in Acute Care, Long Term Care (LTC) and in Home Care (HC).
   - The physician is responsible for writing orders to initiate and maintain NPWT/NPWTi, utilizing the appropriate pre-printed order set:
     - Negative Pressure Wound Therapy order set #102840 or
     - Incision Management System order set #104036 or
     - Negative Pressure Wound Therapy with Instillation order set #104037
   - With the exception of NPWT initiated in the OR, NPWT will only be initiated on a weekend or statutory holiday in targeted acute care practice settings that have access to a NPWT unit and certified staff as identified by this policy (refer to Roles) to support initiation and maintenance.
   - Outside of the OR, NPWT will be initiated as per physician’s order, by:
     - A member of the OWRT (urban Acute Care) or
     - Enterostomal Nurse Educator (Community ETN [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 OWRT utilizing In-patient Wound Referral form #103620.
Referral form #103620. Complex wounds in HC and LTC should be referred to the Community ETN using the Community Wound Resource Referral form

- A complete wound assessment, including wound measurements will be performed prior to the initial application of NPWT/NPWTi and at every dressing change during therapy.

- Complete Wound Care Record #103527 or the appropriate wound assessment form for the clinical area.
- If the wound is to be photographed, complete the Media Consent Form and have it signed by the client or substitute decision maker.

- Aseptic technique will be used.

- Personal Protective Equipment (PPE) 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.

- The NPWT/NPWTi dressing will be changed as per physician’s order.

- Patients are at risk for wound infection or other wound deterioration if NPWT dressings are left in place without active NPWT for longer than two hours. As per current KCI clinical guidelines, the NPWT/NPWTi dressing will be removed if negative pressure is off for a period exceeding two hours. See Appendix C.

- Notify prescribing physician or Most Responsible Physician (MRP) or the OWRT (acute care) or the Community ETN (urban HC and LTC) if NPWT/NPWTi cannot be reapplied.

  **Note:** In rural HC the client can contact their HC office during regular business hours for assistance, or call the 24 hour KCI National Call Center who will provide troubleshooting support.

- 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 Incision Management System kit which will connect the dressing to a NPWT unit if the Incision Management System kit canister fills too quickly or is not providing sufficient negative pressure. The connector will be taped to the inside of the client’s chart. Additional connectors can be ordered from Stores.

- Discontinuation of NPWT/NPWTi 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 A)
  - The client is unable or declines to follow a concordant plan of care

Notify the prescribing physician, or refer to the OWRT (acute care) or the Community ETN (HC and
3. PROCEDURE

- Review physician’s order for NPWT/NPWTi
- To access the appropriate NPWT/NPWTi rental machines – see Appendix B
- To access NPWT/NPWTi consumable supplies – see Appendix B
- Supplies needed – see Appendix C
- Removal – Incision Management System Kit – see Appendix C
- Removal – NPWT/NPWTi – see Appendix C
- Application – NPWT/NPWTi – see Appendix C
- Monitoring during NPWT/NPWTi by Certified and Uncertified Staff – see Appendix D
- Client Discharge or Transfer between Care Providers – see Appendix E
- Cleaning and returning NPWT units – see Appendix F
4. REFERENCES


Is the Wound Appropriate for Negative Pressure Wound Therapy?

Wound Type
- acute/traumatic
- dehisced
- post graft/flap
- highly exudating
- surgically debrided chronic wound
- closed surgical wound at high risk for dehiscence

Optimize best practice wound care:
- wound assessment and documentation
- moist wound healing
- pain management
- management/treatment of infection
- optimize BP/blood glucose
- maximize nutritional status
- appropriate repositioning program
- appropriate pressure redistribution surface
- reassess Braden scale or other risk assessment tool as per unit/facility protocol
- educate client and caregivers

Consider consult:
- Dietitian
- OT and/or PT
- Plastics
- Vascular
- OWRT (acute care)
- Community ETN (HC and LTC)

Are there any contraindications?

Absolute:
- difficult wound hemostasis
- untreated osteomyelitis/infection
- malignancy in wound
- non-enteric and unexplored fistulae
- localized ischemia
- Consult OWRT (acute care)
- Consult Community ETN (HC and LTC)
- Consult physician

Relative:
- inadequate debridement/ necrotic tissue with eschar present
- inflammatory wound
- palliative/maintenance wounds
- client non-concordance
- immune compromised
- exposed ligaments, tendons or nerves (see manufacturers recommendations for application)

YES

NPWT not appropriate

NO

Obtain physician’s order

Review policy and procedure and manufacturer’s clinical guidelines for NPWT prior to initiating therapy
**Work Standard Summary:** This work standard describes the steps required to ensure timely access to NPWT machines and consumable supplies. For the purpose of this Work Standard, NPWT refers to NPWT both with and without instillation.

<table>
<thead>
<tr>
<th>Task Sequence</th>
<th>Essential Steps</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient/resident/client is identified as having a wound that requires NPWT.</td>
</tr>
<tr>
<td>2.</td>
<td>The nurse receives and/or reviews a physician’s order for NPWT.</td>
</tr>
</tbody>
</table>
| 3.            | To access a NPWT rental machine:  
|               | • Acute care nursing units refer to their ward NPWT binder, or the Skin and Wound Care webpage on the InfoNet  
|               | • CPAS notify the Seniors Health and Continuing Care (SHCC) manager of the need for NPWT in LTC.  
|               | • SHCC provides direction to the LTC home to access a NPWT machine through an identified vendor. Refer to SHCC Work Standard: LTC NPWT Requests and Access  
|               | • HC follow their own procedures for accessing a NPWT unit |
| 4.            | To access NPWT consumable supplies:  
|               | • Saskatoon HC and urban Acute Care access NPWT consumable supplies through Stores at Royal University Hospital (RUH), Saskatoon City Hospital (SCH) and St Paul’s Hospital (SPH)  
|               | • Rural HC and rural Acute Care access NPWT consumable supplies through Stores at Humboldt District Health Complex  
|               | • LTC homes (owned and operated and affiliates) access NPWT consumable supplies from a vendor identified by SHCC |
Name of Activity: Removal and Application of a Negative Pressure Wound Therapy (NPWT) dressing

Role performing Activity:
Certified RNs: NPWT Removal and Application.
Certified LPNs or RPNs: NPWT Removal and Application for clients with an established plan of care.
Uncertified RNs, LPNs and RPNs: NPWT removal only

WORK STANDARD

Location:                         Department:

Document Owner:
Equipment and Product Standardization Nurse – Skin & Wound- Saskatoon Area

Region/Organization where this Standard Work originated:
Former Saskatoon Health Region

Date Prepared:  May 2, 2018  Last Revision:  Date Approved:  May 23, 2018

Work Standard Summary: This work standard describes the steps necessary to ensure the safe removal and application of NPWT. For the purpose of this Work Standard, NPWT refers to NPWT both with and without instillation.

<table>
<thead>
<tr>
<th>Task Sequence</th>
<th>Essential Steps</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Nurses who have been identified by their manager in targeted practice settings and are currently educated or certified in this procedure may initiate or remove or reapply a NPWT system.</td>
</tr>
<tr>
<td>2.</td>
<td>Uncertified nurses will only remove a NPWT dressing if negative pressure is off for a period exceeding two hours, and a certified nurse is not available to remove and replace the NPWT system.</td>
</tr>
<tr>
<td>3.</td>
<td>The nurse receives and/or reviews the physician’s order for NPWT.</td>
</tr>
</tbody>
</table>
| 4.            | Supplies needed:  
|               | - If NPWT will not be reapplied, based on wound assessment a dressing will be applied that fills dead space, is atraumatic to the wound bed, and highly absorbent.  
|               | - 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 two 60mL twist top normal saline, or a 35 mL syringe and 19 gauge blunt needle with at least 100mL sterile saline/water
- Protective Personal Equipment (PPE) - protective gown, mask with attached visor
- Waterproof plastic disposable trash bag

5. Prior to removing the dressing, check the Wound Care Record #103527 or appropriate wound assessment form for the 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.


7. Removal – Prevena Incision Management System™ (PIMS)
   - Turn off therapy unit immediately prior to dressing change
   - Perform hand hygiene. Don non-sterile gloves
   - Remove dressing in line with sutures/staples by gently stretching transparent drape horizontally and removing slowly while supporting the exposed skin
   - Once removed the PIMS should not be reapplied. Apply an alternative dressing and notify the prescribing physician or Most Responsible Physician (MRP), or refer to the OWRT (acute care) or the Community ETN (urban HC and LTC) to reassess the treatment plan

8. Removal – NPWT with ActiV.A.C®, V.A.C.Via or V.A.C.Ulta™; NPWTi with V.A.C.Ulta™
   - Administer analgesia if required, as ordered, prior to dressing change.
   - Thirty minutes prior to dressing change, turn off therapy unit and close tubing clamps
   - For incision management dressing changes turn off therapy unit immediately prior to dressing change

9. Prior to removing the dressing, check the Wound Care Record #103527 or appropriate wound assessment form for the 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.


11. 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

12. Remove transparent drape by gently stretching horizontally and removing slowly while supporting the exposed skin.
   - Incision management dressings should be removed in line with the sutures/staples

13. When removing foam, support tissues and surrounding skin.

14. 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.

15. Remove gloves, perform hand hygiene.
16. Application – NPWT/NPWTi
   - Don non-sterile gloves
   - Cleanse the wound/incision as per Wound Irrigation and Packing policy #1030
   - Remove gloves, perform hand hygiene
   - Set-up dressing supplies
   - Insert canister into therapy unit until it locks into place.
   - Don non-sterile gloves. Apply skin barrier to peri-wound skin.
   - Remove gloves, perform hand hygiene
   - Don sterile gloves.

<table>
<thead>
<tr>
<th>NPWT with ActiV.A.C.®, V.A.C.Via or V.A.C.Ultra™</th>
<th>NPWTi with V.A.C.Ultra™</th>
<th>NPWT Incision Management with ActiV.A.C.®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply wound contact layer, if required, to wound bed</td>
<td>Apply wound contact layer, if required, to wound bed</td>
<td>Apply contact layer over incision. The non-adherent layer should be a minimum 7.6 cm wide and extend 2.5 cm over each end of the incision.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
<td>Cut Granufoam so that it is 6.3 cm wide and extends 2.5 cm over each end of the incision.</td>
</tr>
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</table>

17. Apply transparent drape to periwound skin as needed.
   - Cut a piece of drape minimum 17.8 cm width and 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
   - Pinch transparent drape and cut a hole at least 2.5cm diameter through the drape over centre of foam

18. 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

19. Connect canister tubing to TRAC™ pad tubing.
   - Open clamps

20. Turn on power to therapy unit and select prescribed therapy settings.
   - VAC® WhiteFoam dressings require a minimum pressure setting of 125mmHg.
   - For specific target pressure settings for wound types, refer to the VAC Therapy Clinical Guidelines
   - Physician orders required for any increase in pressure settings
### 21. Check dressing to ensure a good seal

### 22. 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

### 23. Write the date and number of pieces and type of dressing materials used on the transparent drape using a permanent black marker pen.

### 24. Documentation - Record application of NPWT on Wound Care Record #103527 or the appropriate wound assessment form for the 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
<table>
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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>All LPNs, RNs and RPNs, including those who are not currently educated or certified in this Specialty Practice/Additional Competency, may monitor the NPWT system during therapy.</td>
</tr>
<tr>
<td>2.</td>
<td>The nurse reviews the physician’s order for NPWT.</td>
</tr>
</tbody>
</table>
| 3.            | The dressing and therapy unit are visually checked every two hours to assess  
|               | • The foam is firm and collapsed  
|               | • The drape and dressing are intact  
|               | • There is no evidence of wound deterioration (increased exudate, pain, erythema)  
|               | • The therapy unit is not alarming  
|               | • The display screen indicates that the therapy unit is active  
|               | • There are no caution messages on the screen  
|               | • The pressure setting is correct  
|               | • Clamps are open and the tubing is not kinked.  
|               | • The type of drainage in the canister  
|               | • The amount of drainage in the canister  
|               | • The canister is not full  
|               | • Battery life |
| 4.            | The prescribing physician or Most Responsible Physician (MRP) is informed immediately if  
|               | • Drainage from the wound fills the canister in less than 30 minutes  
|               | • Frank blood or bowel contents are observed in tubing and/or canister  
|               | • There is evidence of wound deterioration (increased exudate, pain, erythema) |
5. If the NPWT system is not operating effectively, as evidenced by abnormalities noted when visually checking the wound and therapy system (refer to #3), staff who are not currently educated or certified in this Speciality Practice/Additional Competency will contact
   - Certified staff as identified by the NPWT policy (refer to Roles) or
   - A member of the Ostomy Wound Resource Team (OWRT [urban acute care]) or
   - Enterostomal Nurse Educator (Community ETN [urban Home Care (HC) and Long Term Care (LTC)])
who will refer to the VAC Therapy Clinical Guidelines and/or call the KCI National Call Center who will provide troubleshooting support and/or contact the vendor’s local clinical representative.

In rural HC the client can contact their HC office during regular business hours for assistance, or call the KCI National Call Center who will provide troubleshooting support.

6. As per current clinical guidelines, if the NPWT system is off for a period exceeding two (2) hours, the NPWT dressing will be removed. See Work Standard: Removal and Application of NPWT.
   - Certified staff will reapply NPWT or apply an alternative dressing
   - Uncertified staff will apply an alternative dressing
   - Notify prescribing physician or MRP or the OWRT (acute care) or the Community ETN (urban HC and LTC) if NPWT cannot be reapplied.
Appendix E

**WORK STANDARD**

**Name of Activity:** Discharge or Transfer of Clients with Negative Pressure Wound Therapy (NPWT) between care providers

**Role performing Activity:** Nursing, LTC Home, SHCC Manager, Home Care

**Location:**

**Department:**

**Document Owner:** Equipment And Product Standardization Nurse – Skin & Wound - Saskatoon Area

**Region/Organization where this Standard Work originated:** Former Saskatoon Health Region

**Date Prepared:**

February 5, 2018

**Last Revision:**

May 23, 2018

**Date Approved:**


**Work Standard Summary:** This work standard describes the steps necessary to facilitate the transfer of care between care providers of a client with NPWT. For the purpose of this Work Standard, NPWT refers to NPWT both with and without instillation.

<table>
<thead>
<tr>
<th>Task Sequence</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>The nurse reviews the physician’s order for NPWT.</td>
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<tr>
<td>2.</td>
<td>CPAS/Client Case Coordinator is notified when NPWT has been initiated and the client will be discharged or transferred to another care provider e.g. from Acute Care to Home Care (HC) or between HC and Long Term Care (LTC).</td>
</tr>
<tr>
<td>3.</td>
<td>Communication between transferring and receiving care providers is initiated to ensure NPWT can be maintained and a process is in place to obtain supplies.</td>
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<tr>
<td>4.</td>
<td>The discharging ward redirects billing for rental NPWT to the receiving care provider.</td>
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<tr>
<td></td>
<td>- Call 1-800-668-5403 or e-mail <a href="mailto:kciorders@kci1.com">kciorders@kci1.com</a></td>
</tr>
<tr>
<td></td>
<td>- LTC refer to SHCC Work Standard: LTC NPWT Education and Support</td>
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<tr>
<td>5.</td>
<td>Whenever possible, clients being transferred to Saskatoon HC or rural HC will have a NPWT rental unit changed to a HC owned unit prior to discharge. A HC unit will be couriered to the acute care site and ward. CPAS will</td>
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<td></td>
<td>- Alert HC with an estimated discharge date</td>
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<td></td>
<td>- Provide HC with client’s name, HSN, location in acute care</td>
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<tr>
<td></td>
<td>- Confirm date and time client is to be discharged</td>
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<tr>
<td></td>
<td>- Send completed NPWT pre-printed order set appropriate to the therapy being utilised</td>
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</table>

If a HC owned unit is not available, HC will require the serial number of the rental unit being sent with the client.
6. Discharge teaching is provided to clients referred to Saskatoon HC or rural HC utilizing “Discharge Instructions for Patients with Negative Pressure Wound Therapy” (#104108).

7. Information is 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 the 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

NPWT dressing supplies are sent with clients going to LTC or rural areas. This should be discussed with the receiving care provider.

8. 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

Appendix F
### Work Standard Summary

This work standard describes the steps required to ensure NPWT machines are cleaned and consumable supplies are disposed of appropriately. For the purpose of this Work Standard, NPWT refers to NPWT both with and without instillation.

<table>
<thead>
<tr>
<th>Task Sequence</th>
<th>Essential Steps</th>
</tr>
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</table>
| 1.            | To return a NPWT rental machine:  
  - Acute care nursing units refer to their ward NPWT binder, or the Skin and Wound Care webpage on the InfoNet  
  - LTC homes (owned and operated and affiliates) refer to SHCC Work Standards for NPWT  
  - HC follow their own procedures for cleaning and maintaining HC owned NPWT units |
| 2.            | To dispose of NPWT consumable supplies:  
  - Acute Care and Home Care refer to ward/facility NPWT binder or the Skin and Wound Care webpage on the InfoNet  
  - LTC homes (owned and operated and affiliates) refer to SHCC Work Standards for NPWT |