

STANDARDIZED PROCEDURE

WOUND DEBRIDEMENT (Adult, Neonatal, Peds)

I. Definition

The purpose of this standardized procedure is to allow an Advanced Health Practitioner (AHP) to safely debride a wound. This procedure will take place when:

1. A wound shows evidence of non-viable tissue that is unlikely to be adequately managed by local wound care (dressing regimens, topical agents)
2. Removal of the non-viable tissue would accelerate wound healing
3. There is a clinical suspicion of an associated wound infection

II. Background Information

A. Setting:

The setting (inpatient vs outpatient) and population (adults vs pediatrics) for the AHP is determined by the approval of the privileges requested on the AHP Privilege Request Form. If the procedure is being done on a Pediatric patient, make sure Child Life Services is involved and use age appropriate language and age appropriate developmental needs with care of children, as appropriate to the situation.

B. Supervision

The necessity of this protocol will be determined by the AHP in collaboration with the supervising physician or his/her designee. Designee is defined as another attending physician who works directly with the supervising physician and is authorized to supervise the AHP.

Direct supervision will not be necessary once competency is determined, as provided for in the protocol. The AHP will notify the physician immediately upon being involved in any emergency or resuscitative events or under the following circumstances:

1. Patient decompensation or intolerance to the procedure
2. Evidence of fasciitis or dehiscence
3. Evidence of tunneling
4. Evidence of involvement of vital structures
5. High fever, marked leukocytosis, or expanding cellulitis
6. Outcome of the procedure other than expected

C. Indications

1. Necrotic tissue that would impair wound healing
2. A clinical suspicion of infection
3. Exceptional tenderness at or adjacent to the wound

D. Precautions/Contraindications

1. The patient may need wound culture and antibiotics
2. Cellulitis should be determined

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3. The wound bed must be carefully examined for evidence of fasciitis or dehiscence
4. An assessment of the appropriate laboratory work is required prior to opening of the wound, i.e. hematocrit $\leq 25\%$, platelet count $\leq 50,000$, INR ≥ 1.5

III. Materials

A. The following materials may be required:

1. Tissue forceps
2. Tissue scissors
3. Cotton-tipped swabs
4. Normal saline
5. Dressings (gauze, Xeroform, Kerlex)
6. Tape
7. Silver nitrate cautery sticks
8. Culture tube
9. Scalpel

IV. Wound Debridement Procedure

A. Pre-treatment evaluation

1. The wound will be inspected by the AHP or a physician to determine the necessity for debriding the wound, the expected outcomes of the procedure and the treatment plan.
2. Evaluate for the potential to experience pain and pre-medicate as appropriate.

B. Set up

Gather all necessary supplies

C. Patient Preparation

1. Inform the patient of the treatment plan, which includes wound debridement.
2. Position the patient in a comfortable position that gives adequate access to the wound.
3. Perform a time out with all of the appropriate steps.

D. Procedure

1. Remove dressings
2. Put on sterile gloves or clean gloves, as appropriate
3. Perform sterile preparation and draping of the wound area, as appropriate
4. Sharply cut away the non-viable tissue until bleeding tissue is encountered
5. The AHP may not excise arteries, veins, nerves or tendons without specific discussion and approval from the Vascular Surgery team and/or responsible attending

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6. Control bleeding initially with direct pressure; if bleeding persists, use silver nitrate cautery sticks or place a suture as needed
7. If the patient experiences pain, avoid further debridement in area that produces pain
8. Collect culture specimen if indicated
9. Pack the wound as needed, then dress

E. Post-procedure

1. Send culture if indicated
2. Record the procedure (including the presence of any purulence under the non-viable tissue, and whether viable tissue was reached), the outcome and the plan in a progress note in the medical record

F. Follow-up treatment

1. Monitor the wound and the patient periodically for recurrence of tissue necrosis, developing infection or cellulitis and possible need for further debridement and/or antibiotic therapy.
2. Instruct the patient on wound care/dressing changes and on the signs and symptoms of infection. This is in anticipation of continued healing by secondary intention.
3. Consider referral for home care.

V. Documentation

A. Documentation is in the electronic medical record

1. Documentation of the pretreatment evaluation and any abnormal physical findings.
2. Record the time out, indication for the procedure, procedure, appearance of the wound after debridement, EBL, the outcome, how the patient tolerated the procedure, medications (drug, dose, route, & time) given, the presence of and a description of any purulent collections, complications, and the plan in the note, as well as any teaching and discharge instructions.

B. All abnormal or unexpected findings are reviewed with supervising physician.

VI. Competency Assessment

A. Initial Competence

1. The AHP will be instructed on the efficacy and the indications of this therapy and demonstrate understanding of such.
2. The AHP will demonstrate knowledge of the following:
 - a. Medical indication and contraindications of wound debridement
 - b. Risks and benefits of the procedure

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- c. Related anatomy and physiology
 - d. Consent process (if applicable)
 - e. Steps in performing the procedure
 - f. Documentation of the procedure
 - g. Ability to interpret results and implications in management.
3. AHP will observe the supervising physician perform each procedure three times and perform the procedure **three** times under direct supervision.
 4. Supervising physician will document AHP's competency prior to performing procedure without direct supervision.
 5. The AHP will ensure the completion of competency sign-off documents and provide a copy for filing in their personnel file and a copy to the medical staff office for their credentialing file.

B. Continued proficiency

1. The AHP will demonstrate competence by successful completion of the initial competency.
2. Each candidate will be initially proctored and signed off by an attending physician. AHP must perform this procedure at least **three** times per year. In cases where this minimum is not met, the attending, must again sign off the procedure for the AHP. The AHP will be signed off after demonstrating 100% accuracy in completing the procedure.
3. Demonstration of continued proficiency shall be monitored through the annual evaluation.
4. A clinical practice outcomes log is to be submitted with each renewal of credentials. It will include the number of procedures performed per year and any adverse outcomes. If an adverse outcome occurred, a copy of the procedure note will be submitted.

VII. RESPONSIBILITY

Questions about this procedure should be directed to the Chief Nursing and Patient Care Services Officer at 353-4380.

VIII. HISTORY OF POLICY

Revised Oct 2012 by the Subcommittee of the Committee for Interdisciplinary Practice

Reviewed Oct 2012 by the Committee on Interdisciplinary Practice

Prior revision Nov 2008

Approved Oct 2012 by the Executive Medical Board and the Governance Advisory Council.

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