Connecticut Valley Hospital Nursing Policy and Procedure	**SECTION D: PSYCHOLOGICAL ADAPTATION** **CHAPTER 19: WOUND CARE** **POLICY AND PROCEDURE 19.3 Wound Care Monitoring and Documentation**
Authorization: Nursing Executive Committee	Date Effective: May 1, 2018 Scope: Registered Nurses and Licensed Practical Nurses

Standard of Practice:
The registered nurse will assess all patient wounds upon discovery and institute care/treatment measures until such time as the wound is resolved.

Standard of Care:
The term *wound* covers a wide range of diseases and morbidity such as trauma, burns, surgical wounds, pressure ulcers, necrosis of limbs caused by critical limb ischemia due to diabetes, Peripheral Artery Disease (PAD), venous stasis and so forth.

Several factors affect skin health and healing such as nutrition, medication, hydration, sun, irritants, friction, and various disease states.

The patient can expect a professional assessment of his/her *wound* and appropriate care and monitoring based on best practices.

Policy:
Registered nurses shall routinely assess and document skin integrity until a wound is resolved, documenting daily on CVH-617 (Wound Care Flow Sheet).

Procedure:
A. Upon discovery of a wound, the RN will make a skin integrity assessment noting the following in a narrative Integrated Progress Note in the Progress Note Section of the Medical Record
   1. Anatomic location and probable etiology of the wound
   2. Exudate – color, amount and odor (if any)
   3. Edges – rolled, loose (undermined) or tightly adhered (measured weekly)
   4. Depth – superficial or full-thickness, tunnels
   5. Base – clean or sloughy, color, moisture
   6. Surrounding skin – intact, red, indurated, and/or tender

B. Notify the ACS Provider/On-Call Physician of the wound to allow for patient assessment, and prescribing of necessary treatments, and frequency of monitoring until such time that the wound is healed/resolved.

C. Initiate CVH-617 Wound Care Flow Sheet, completing required sections. Document daily on the Wound Care Flow Sheet until completely healed. Active Wound Care Flow Sheets shall be kept in the Treatment Kardex.

D. The wound shall be measured weekly on **Wednesday's** (length, width, and depth) unless otherwise contraindicated. Pressure ulcers will be staged upon initial assessment. All wounds will be identified on the patient's Nursing Plan of Care with corresponding interventions. Completed Wound Care Flow Sheets are then filed in the Progress Note Section of the Medical Record.

E. Additional notations in the Integrated Progress Notes shall address interventions used to prevent the further development/breakdown of ulcers and/or use of, (special mattresses, protective dressings, barrier creams, skin cleanser with protectant and pressure relief devices). Also recorded are any cultures obtained, date, time and results.

F. Dressings shall be assessed each shift to ensure the wound is clean, dry and dressing is intact and dressing care documented in the Progress Note Section of the Medical Record.

G. The dressing will be dated, timed and initialed by the nurses at the time of application and/or change.

H. Notify Infection Prevention for the presence of a wound, signs and symptoms of infection, ordered cultures and antibiotic orders.