Wound Protocol: Assessment, Treatment, Collaboration of Care & Prevention

ASSESSMENT:

1. Registered nurse will assess any skin area of concern reported by care staff and assess for type, severity, and possible causes with assistance from care staff and site administrator.
2. Administrator or nurse will notify PCP if a wound is found after assessment for proper diagnosis and treatment.

    a. If resident's wound can be treated by/ within nurse's scope of practice (skin tear, bruising, swelling), nurse will outline and institute interventions to address resident's specific wound treatment needs.

3. Nurse will assess and review if facility, care staff, and nursing availability is adequate for meeting the resident's wound needs.

TREATMENT:

1. Nurse will perform wound care as ordered by PCP (if any new orders) or as outlined via interventions set by nurse.
2. Nurse will educate care staff and administrator on care of the wound delegated within their scope of practice including when to notify nurse of wound changes, simple dressing changes or wound care, and interventions to prevent further wound progression.
3. NSA will be updated with resident's specific wound protocol until healed.

COLLABORATION OF CARE:

1. If outside services are ordered (home health, wound clinic, hospice) the nurse will collaborate care plan for resident based on the needs of the wound specific to that resident.
2. Nurse will have ongoing collaboration of care to address wound until it is deemed healed or outside services are discontinued.

PREVENTION:

1. Nurse and administrator will collaborate and construct a resident specific prevention plan including clear interventions to prevent further or more injuries.
2. NSA will be updated with resident's specific plan for future wound prevention.