**Infection Prevention During Wound Care**

**Date Implemented:**

**Review/Updated Date:**

**Policy**

The elderly population present with many chronic and acute wounds that require appropriate infection control and prevention measures to prevent deterioration and further complications to an inherent high-risk population. It is vital that nurses follow strict infection control and prevention measures to mitigate infection risk in residents.

Wounds in the elderly population present in many different forms including but not limited to surgical, skin tears, abrasions, cellulitis and other skin infections, venous/arterial ulcers, diabetic and pressure ulcers. Nurses must appropriately assess the wound type and consult with physicians and/or specialized wound nurses to assure adequate treatment of the wound. Ongoing assessment is critical to assure that the wound healing progression is adequate and whether further interventions are necessary to aide with healing.

While general wound management and prevention is covered in a separate policy and procedures, this policy and procedures focuses on infection prevention during wound care. The elderly population is at an increased risk for antibiotic resistant organisms developing in wound beds, whether through direct or indirect contact. While some antibiotic resistant organisms are acquired in a communal living setting, many residents may already have antibiotic resistant organisms colonized in their body, further increasing the chances of a wound infection.

A skin or wound provides a portal of entry for bacteria that are not already present in a resident’s body. A skin or wound infection may present with a multitude of signs and symptoms. While one sign or symptom of infection may not be indicative of an infection, it can trigger a need for consultation with the resident’s attending physician or wound clinic, as applicable. Signs and symptoms include but are not limited to:

* Puss present at a wound, skin or soft tissue site
* Heat to the localized area, identified by touching the area or surrounding skin
* Redness to the wound bed and/or surrounding skin
* Swelling at the wound bed or to areas surrounding the wound
* Tenderness or pain
* Serous or purulent drainage
* Fever and/or leukocytosis

Wound care increases the risk for pathogen transmission by the health care professional by:

* Allowing lapses in hand hygiene
* Improper selections and use of personal protective equipment and changes when appropriate in personal protective equipment
* Splashes or sprays generated during irrigation of colonized or already infected wounds
* Contamination by improperly disinfection of equipment
* Contamination of products and/or equipment by improper handling
* Failure of health care personnel to follow appropriate wound care standards of practice

**Procedures**

Dressing Changes:

* Dressing changes should be completed as ordered by the physician, including an as-needed basis to allow for soiled dressings to be changed as indicated.
* Dressing changes should be performed in a clean environment that allows for a lessened chance of contamination. Generally, dressing changes are completed in a private location such as the resident’s room but may be completed in other private locations depending on the circumstances, for example the shower room following a shower. The location of a dressing change is referred to as the “care area” in this policy and procedures.
* General infection control guidelines related to dressing changes include:
	+ Equipment:
		- All equipment should be gathered prior to entering the care area. Additional trips to gather supplies leads to an increased chance of contamination of the resident’s wound or contamination of areas touched by the nurse.
		- Only equipment necessary to complete the dressing change should be taken into the care area. Taking excess dressings into the care area will require the unused dressings to be stored safely in the resident’s room or be discarded. Unused dressing supplies cannot be restocked.
		- When removing equipment (such as scissors) from a care area, the health care provider shall appropriately disinfect all items prior to placing on or in a treatment cart.
	+ Barriers:
		- Any items utilized for dressing changes should be placed on a barrier to prevent contamination of the items from the resident’s belongings.
		- Barriers can include but are not limited to disposable pads and/or clean towels or washcloths.
		- A separate barrier should be used for contaminated items once they have been used for the dressing change to prevent contamination of the resident’s environment or contamination of clean items.
		- Soiled dressings should be discarded immediately upon removal.
	+ Medications:
		- Any medication required for a dressing change shall also be placed on a barrier. Medications should be dedicated to one resident only, or a small amount of medication shall be taken into the care area in an appropriate manner, such as placing cream in a disposable medication cup.
	+ PPE Use:
		- Standard Precautions should be used at all times, including hand hygiene.
		- If the wound presents with a large amount of drainage, additional items, such as a facemask and eye protection, may be indicated.
		- If the resident requires transmission-based precautions, additional measures may be indicated, including a gown, mask, and eye protection.
		- Gloves must be changed each time a nurse performs a “dirty” procedure and is going to a “clean” procedure. For example, upon beginning the dressing change, the nurse will perform hand hygiene and don gloves. The nurse will remove the old dressing and discard. The nurse will then doff gloves, perform hand hygiene, and will don a new pair of gloves before moving onto cleaning the wound.
		- Each time the nurse changes or removes their gloves, hand hygiene must be completed. Generally, alcohol-based hand rub can be utilized, however, handwashing may be required.
	+ Nurses should follow standards of practice for dressing changes including cleansing from the inside to the outside to prevent contamination of the wound bed and not re-using the same area of a wipe, gauze, or washcloth to cleanse more than one time.
	+ Equipment and dressing supplies shall never be placed into a health care providers scrub or jacket pocket.

**Resources**

CMS. (2017, Nov. 2). *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, F880*. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>

CDC. (2020, June 10). *Infection Prevention Training | LTCF*. <https://www.cdc.gov/longtermcare/training.html>