Standing Order for Wound Assessment, Preliminary Care, and Referral

Purpose: To reduce morbidity from wounds related to injection drug use in New Jersey.

Policy: Under these standing orders, the Harm Reduction Health (HRH) nurse is authorized to assess wounds, provide preliminary wound care, where available, and refer for ongoing wound management to clients attending the HRH Programs in New Jersey.

Background: Skin and soft tissue infections are common among people who inject drugs (PWID). It is estimated that up to one-third of PWID have wounds including abscesses and cellulitis. In addition, injecting drugs can lead to other adverse subcutaneous effects, including thrombophlebitis, venous sclerosis, lymphedema, superficial scarring and discoloration, chronic venous insufficiency, and ulcers. Injected-related wounds are an important clinical and public health complication of injection drug use.

In general, the goal of the HRH nurse's evaluation of a wound is to determine which wounds prompt an immediate referral to an emergency room for management and which wounds are clinically stable can be treated on site or need to be assessed in a primary care setting for incision and drainage and/or conservative treatment such as antibiotics or warm compresses. This standing order also authorizes the HRH nurse to provide preliminary wound care, including but not limited to cleaning wounds, changing dressings, and applying over-the-counter anti-bacterial ointments.

Wound Assessment and Referral Procedure

1. **Ask clients of the HRH Program if they have any skin changes that they are concerned about.** People who inject drugs are less likely to seek medical care for wounds, so the HRH nurse should ask clients proactively.

2. **Assess the wound.** Look specifically for the following signs and symptoms of an advancing infection and determine whether the wound is stable but requires further evaluation or whether the wound requires immediate evaluation in the nearest emergency room.
    - Fever and/or chills
    - Swelling greater than baseline
    - Redness, progressing or widespread
    - Tenderness or pain at site
    - Heat
    - Malodorous or pus-like drainage

- New onset firmness or fluctuance of subcutaneous tissue in a localized area
- Skin or tissue falling off body or presence of crepitus
- Wounds/sign(s) of infection near or over a joint

Clients with compromised immune systems may not mount vigorous immune responses. Use caution when assessing wounds of known HIV-positive clients and clients who have type 1 or 2 diabetes.

3. **Signs and symptoms of sepsis, wound botulism, and/or cellulitis that would prompt an immediate referral to the nearest emergency room include but are not limited to:**
   - High fever, over 102.5
   - Difficulty breathing
   - Difficulty swallowing or talking
   - Changes in vision
   - Altered mental status
   - Redness, tenderness or pain at site
   - Rapid or significant degree of swelling i.e. concern for compartment syndrome

4. **Refer for ongoing wound management when the wound is deemed clinically stable.** Provide the client all contact information for referral and where possible call and make appointments with the provider. Provide written or graphic instruction for where to go for follow-up appointments.

5. **Provide preliminary wound care,** where supplies, appropriate space, and lighting are available within HRH Programs and the HRH nurse has determined that the delivery of wound care is appropriate for the client.
   - **Wound definitions:**
     - Granulation tissue: pink to beefy-red, healthy tissue type within wound bed
     - Slough: yellow, tan, green necrotic tissue type, can be moist or dry
     - Eschar: black, brown, grey-brown necrotic tissue type, generally dry but can be seen in wet wounds as well
     - Periwound area: 4cm of skin beyond wound border in all directions
     - Primary wound dressing: any dressing supplies in direct contact with wound bed
     - Tunneling: channels that develop away from a wound or abscess, high risk of infection
     - Undermining: area(s) along border of wound where skin and wound bed are no longer adhered

- **Step 1: Cleanse/irrigate wound and periwound area and dry completely**
    - **o** Can use gentle soap and water, normal saline, dermal wound cleanser, or Vashe
        - Discuss with client which option they can tolerate
    - **o** If older dressings in place, be sure to soak with clean water or normal saline before removal to avoid potential damage to underlying wound bed and/or cause pain
    - **o** Assess for areas of tunneling or undermining that should be irrigated

- **Step 2: Apply debriding agent to necrotic tissue**
    - o Can use xeroform cut to size needed (no larger than total wound bed size) or apply manuka honey-based products (i.e. Medihoney) directly
    - o If significant necrosis present, connect to provider for prescription-strength enzymatic debriding agent (i.e. Santyl)
    - o If these options unavailable, can apply thin layer of A&D ointment until debriding agent an option
    - o Of note, provide education that drainage may increase with use of these agents

- **Step 3: Apply primary dressing supply to granulation tissue**
    - o If wound bed appears heterogenous it is important to protect healthy tissue from debriding agents
    - o <u>For moist granulation tissue</u>:
        - Apply thin layer of A&D ointment **OR** option that promotes wound healing, such calcium alginate or Aquacell
        - An oil emulsion dressing (i.e. Adaptic) can be placed either over primary dressing supply to protect from adhering to outer dressings or directly to tissue alone
    - o <u>For dry granulation tissue</u>:
        - Apply thin layer of A&D ointment **OR** apply xeroform or oil emulsion dressing directly to tissue
    - o Of note, with moist primary dressing supplies, cut to size needed only and avoid placing in periwound area to avoid maceration of wound border/periwound area

- **Step 4: Assess severity of drainage and if periwound area is at risk of maceration**
    - o <u>For wounds with moderate to severe amounts of drainage</u>:
        - Apply THIN layer of A&D to periwound area
        - Place absorbent dressing (i.e. abdominal pads, medical foam) on top of primary dressing and/or debriding agent
    - o <u>For dry, or minimally draining wounds</u>:
        - Apply THIN layer of A&D to periwound area
        - Place non-adherent pad on top of primary wound dressing and/or debriding agent

- **Step 5: Outer dressings**

- Before securing outer dressing, recommend wrapping a layer of gauze (either from roll or sterile package) over dressing for comfort and added absorption
- **o** Outer dressing wraps:
  - Self-adhering wrap – caution not to secure overly tight, it is highly compressive and if wrapped too tight, will trap swelling distal to dressing
  - ACE bandages – ideal option, especially when wounds nearby a joint
- **o** For smaller wounds, can cover with gauze and medical tape, or Tegaderm transparent dressing
  - Ask if any adhesive allergies or sensitive skin before using
  - Avoid bandaids for extended periods of time as can trap moisture and increase risk of maceration

- **Wound care can be significantly painful**
  - Where appropriate, refer to prescribing clinician for pain management before dressing changes
  - Also consider if patient in need of withdrawal management

6. **Time permitting, provide client education about basic wound care/wound healing and relevant harm reduction strategies for injection-drug use:**

- Keep affected areas clean and dry, replace dressing if it gets wet or becomes overly saturated with drainage before next expected dressing change
- Do not use hydrogen peroxide, alcohol or alcohol-based cleansers to clean open wounds
- Provide counseling on nutrition specific to improving wound healing
- Refer clients for support with nutrition-related needs, can refer to:
  - Nutritionist for wound healing-specific diet recommendations
  - Local food banks/pantries, community fridges, meal services
  - Provider for assessment of nutritional supplementation
- Review expectations regarding timeline for wound healing
- Provide education on wound care plan specific to individual being treated and provide appropriate wound care supplies
- Always clean injection site(s) with alcohol or soap and water prior to and after injection
- Rotate injection sites
- Avoid injection sites in the neck or near arteries e.g., fingers or toes, wrists and groins

- Avoid, if possible, injection into or near current wounds
- Connect clients with services who can assist in improving current injection techniques

7. **Record image of wound, including wound border and periwound area, presence and characteristics of drainage, and management in nursing medical record.** Record delivery of wound assessment and/or care in the database.

This policy and procedure shall remain in effect until rescinded or until _____(date).

Medical Doctor's signature: _____ Effective date: _____

Reference: Breen JO. Skin and soft tissue infections in immunocompetent patients. Am Fam Physician. 2010 Apr 1;81(7):893-9.