C·B·H

a division of DBHIDS

REFERENCE GUIDE

ASAM 3.7 Medically Monitored Intensive Inpatient Services Wound Care

Updated May 2025

Community Behavioral Health

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1. BACKGROUND

The **Philadelphia Department of Public Health** (PDPH) **recorded 1,413 unintentional overdose deaths in 2022**. This is an 11% increase from the previous high of 1,276 in 2021. One in every three overdose deaths in Philadelphia involved xylazine. As a result, The **Philadelphia Department of Behavioral Health and Intellectual Disability Services** (DBHIDS) identified the growing incidents of individuals experiencing substance use disorder (SUD) with moderate to severe wounds unable to access SUD rehabilitation services due to wounds and lack of expertise available for care and, beginning in summer 2022, investigated solutions to meet the needs of the changing population.

DBHIDS launched the L4 Post-Acute Care (L4PA) Program on March 15, 2023, to address the most acute needs of this population—persons who inject drugs (PWID)—and require 2-12 weeks of intravenous (IV) antibiotics and/or extensive wound care after a hospitalization. The rehabilitation programs developed the necessary policies, procedures, and core competencies to care for this vulnerable population. In one year, 400 eligible cases were identified in the acute care hospital setting. 200 of these cases were admitted to the L4PA program, with two out of three individuals completing medical treatment. Over 50% continued rehabilitation services in a step-down unit. The average length of stay (LOS) was 32 days, ranging from 5-71 days. This program has saved over $5 million for the Medicaid system since its inception and is anticipated to save $5-6 million annually.

During the implementation of the L4PA program, DBHIDS identified the need for similar access to bed-based recovery service and wound care for individuals who need moderate wound care (1-2 times daily for 15 minutes or less per wound) with or without oral antibiotics. Several steps were taken to define the problem, engage key stakeholders, and develop a sustainable program within the **American Society of Addiction Medicine** (ASAM) 3.7 level of care (LOC) requirements and rates. An assessment of all ASAM 3.7 bed-based recovery programs indicated that only one program had implemented the required policies, procedures, and staff competencies to meet the needs of individuals with moderate wounds. CBH validated that moderate wound care and oral antibiotics are considered within the ASAM 3.7 LOC and are already funded through existing per diem rates.

DBHIDS and **Community Behavioral Health** (CBH) developed this ASAM 3.7 Wound Care Reference Guide to assist programs in meeting **ASAM 3.7 Medically Monitored Intensive Inpatient Services**. It includes policies, procedures, staff education, and competencies for providing moderate wound care and oral antibiotics for individuals seeking bed-based recovery services.

2. PROGRAM PHILOSOPHY AND GOALS

2.1. Philosophy

To meet the medical needs of people who use drugs (PWUD) who require ASAM 3.7 Medically Monitored Intensive Inpatient Services and moderate wound care by creating access and expanding the skills and services provided in ASAM 3.7 programs.

2.2. Program Goals

- **Goal #1:** Reduce medical and system access barriers for PWUD by increasing the number of ASAM 3.7 programs that provide quality care for individuals with moderate wounds who may need oral antibiotics.
- **Goal #2:** Promote opportunity for "reachable moments" in ASAM 3.7 care to complete medical treatment and offer continued rehabilitation treatment services.
- **Goal #3:** Reduce Medicaid system costs by reducing physical health readmission rates, improving wound treatment completion rates, and providing access to more appropriate LOCs.
- **Goal #4:** Improve the experience of PWUD with moderate wounds by providing more access to bed-based rehabilitation services that offer high-quality wound care consistent with ASAM 3.7 Medically Monitored Intensive Inpatient Services.

3. DESCRIPTION OF SERVICE

This program aims to meet the ASAM 3.7 medical and behavioral health needs of PWUD by certifying ASAM 3.7 programs with policies, procedures, and staff education and competencies consistent with high-quality wound care management. The program will focus on developing a partnership with at least two DBHIDS-approved ASAM 3.7 providers and will ensure that care is delivered consistent with ASAM 3.7 treatment guidelines and CBH-contracted service levels.

4. TARGET POPULATION

The primary population will be adults 18 years and older who qualify for ASAM 3.7, based on **the ASAM Criteria, 3rd Edition**, who are interested in participating in bed-based rehabilitation services and require moderate wound care.

4.1. Admission Criteria

- 18 years and older
- Diagnosed with SUD and actively using drugs
- Eligible for ASAM 3.7 care based on the **ASAM Criteria Assessment Interview Guide**
- Eligible for CBH insurance or Behavioral Health Special Initiative (BHSI)
- Medically stable and able to ambulate with or without assistive devices (e.g., walker, cane) and able to self-transfer in the bathroom
- Requires medically managed wound care that
  - Does not require daily physician interaction
  - Has a frequency of 1-2 times daily based on physician orders
  - Has a treatment time of 15 minutes or less per wound

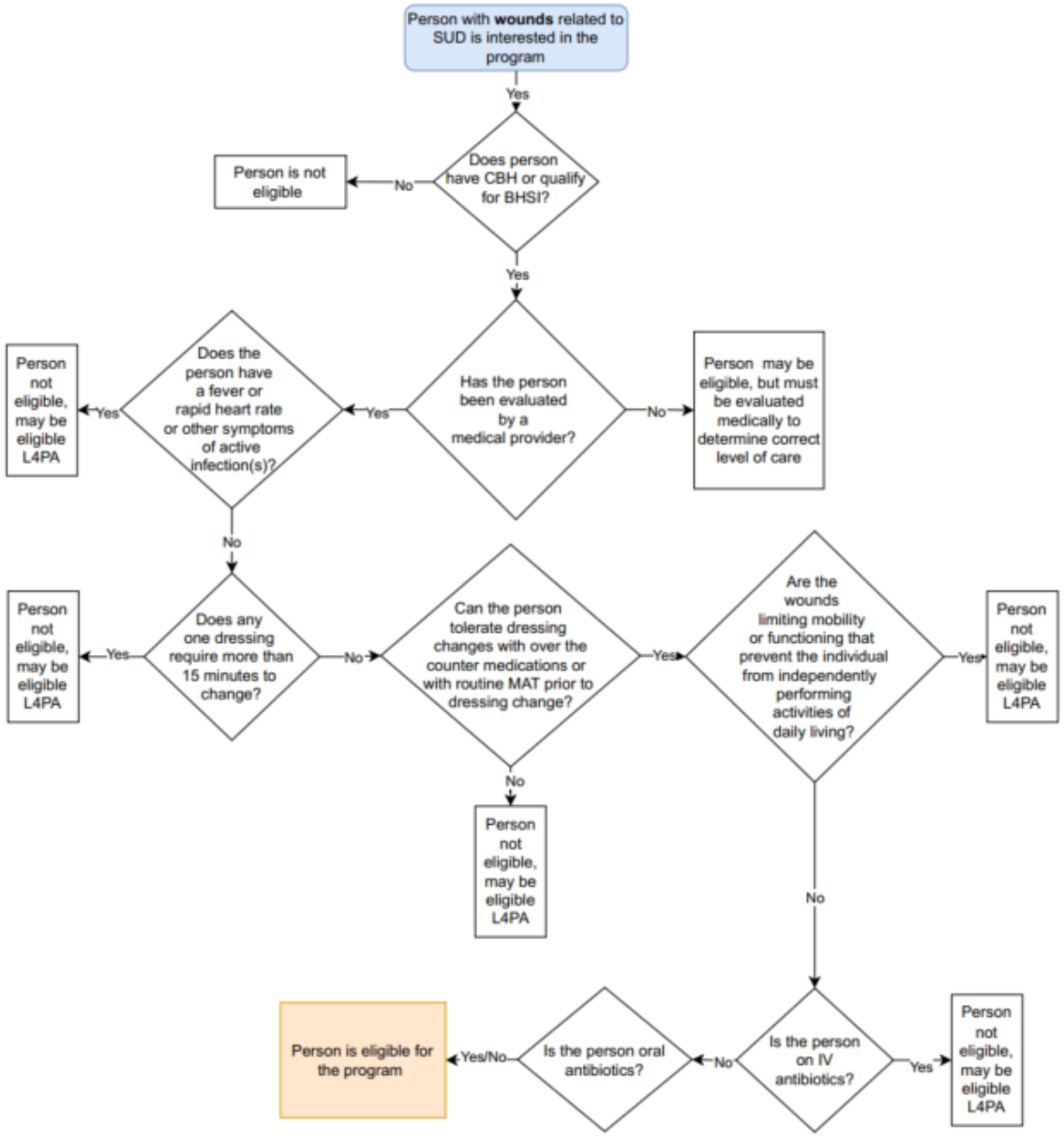
  - Does not require pain medications related to dressing changes
- May require oral antibiotics, not IV antibiotics
- Requires medication-assisted treatment (MAT) per physician order
- Agreeable to all required admission testing, including CBC, basic metabolic panel if indicated, and other testing such as HIV and Hep C
- Agreeable to follow the guidelines of the facility providing care (e.g., visitation, personal property, etc.)

5. REFERRAL PATHWAYS

Referrals to the ASAM 3.7 Wound Care Program may come from multiple sources, such as:

- Crisis response centers (CRCs)
- Mobile units
- Emergency rooms
- Self-referral as a walk-in
- Transfer from another behavioral health provider

6. ASAM 3.7 WOUND CARE PROGRAM DECISION TREE



7. ASAM 3.7 WOUND CARE PROGRAM ORGANIZATIONAL MILESTONES

The following milestones are required to effectively launch a wound care program in ASAM 3.7 care settings and sustain it for individuals experiencing SUD and wounds.

Milestone	Rationale	Considerations	Available Resources
Complete readiness assessment survey	Determine organizational preparedness to launch a program for wound care	Gap analysis for existing resources, competencies, policies, procedures and protocols	DBHIDS 3.7 Wound Care Readiness Assessment
Create project tiger team	***A Tiger Team** is a specialized, cross-functional team brought together to solve or investigate a specific problem or critical issue.* This project team will be together for the duration of the program development, implementation and evaluation periods.	Recommended Members: ➡ Medical Director ➡ Administration team lead ➡ Admission team member ➡ Certified Recovery Specialist ➡ Lead Clinical Nurse ➡ Staff trainer ➡ Social worker/care management (optional)	N/A
Create a project plan	A project plan is a critical step in project management that helps ensure a project is completed successfully. It can help with: ➡ Setting goals ➡ Creating a strategy ➡ Keeping everyone accountable ➡ Avoiding problems ➡ Optimizing resources	Consider timelines and other projects and priorities of the organization and adjust target dates to accommodate.	Appendix A
Develop Wound Care Program comprehensive policies and procedures	Create an organizational policy and procedure that guides staff on wound assessment, documentation, and management. This should support standardized clinical decision-making and ensure consistency. Include competency of training by staff job title. This policy should clearly state that a physician order will	Consider ➡ Levels of staff (LPN/RN/BHT) and escalation paths ➡ Location where wound care is performed ➡ Wound Care Supplies ➡ Supply storage ➡ Documentation	➡ Appendix B ➡ Appendix C ➡ Appendix F

Milestone	Rationale	Considerations	Available Resources
	define wound care treatment options. Physician orders should align with the policy and procedure to assure use of supplies that are available at all times.	➡ When to contact a provider or Wound Care Specialist ➡ Include infection prevention and control measures as they relate to wounds ➡ Wound photos if facility policy allows (OPTIONAL)	
Review/Refine/Develop MAT/MOUD policies and procedures	Create an organizational policy and procedure that guides staff on MAT/MOUD induction, titration and maintenance, either as an offering by the facility or in partnership with an outside organization. This can also support standardized clinical decision-making and ensure consistency.	If not offering MAT in the facility, including induction, titration and maintenance, the organization must provide guidance on how to coordinate with an external contracted partner organization. Assure relevant DDAP licensure for extended MAT administration in 3.7 LOC.	Use internal policy
Review/Refine/Develop pain management policy and procedure (OPTIONAL)	Create an organizational policy and procedure that guides staff on pain management, documentation, and supportive patient care. This can also support standardized clinical decision-making and ensure consistency.	Consider how to address pains associated with dressing changes and, for patients who may not be referred with pain management, or from an outside facility.	Veterans Administration Pain Management Resources
Develop education program for staff	Ensure staff can identify different types of wounds and dressings, such as ulcers, pressure injuries, and skin tears.	Consider levels of staff (LPN/RN/BHT) and escalation paths. Include staff training on working with individuals with wounds and trust building to ensure completion of treatment. Consider module on education to patients: ➡ Provide patients with evidence-based resources on how to manage their wounds and recognize signs of improvement or decline. You can also teach patients first-aid techniques, such as how to wash their hands, stop bleeding, clean wounds, and apply antibiotic	Appendix D

Milestone	Rationale	Considerations	Available Resources
		ointment or petroleum jelly.	
Wound care treatment area/room	Allows for control of supplies and maintains clean environment to encourage healing	A wound care room with supplies to increase efficiency of dressing changes, provide privacy for patients, and limit wound odor exposure for other clients	N/A
Implement and complete staff training	Once wound care module finalized, begin to train staff who are selected to support initiative	Consider wound assessment training to refine training materials.	Appendix E

8. READINESS ASSESSMENT

All ASAM 3.7 providers must complete the DBHIDS 3.7 Wound Care Readiness Assessment. The questions to be considered are below.

1. Please select your organization. ☐ BeWell @ Girard ☐ Eagleville Hospital ☐ Gaudenzia ☐ Keystone ☐ Kirkbride Center ☐ Malvern Institute ☐ Valley Forge	2. Primary contact name and email	3. Total licensed 3.7 beds ☐ 10 or less ☐ 10 - 20 ☐ 20 - 30 ☐ 30 - 40	4. Total licensed 3.7 flex beds ☐ 10 or less ☐ 10 - 20 ☐ 20 - 30
5. Total 3.7 WM ☐ 10 or less ☐ 10 - 20	6. Does your facility have access to pharmacy services to obtain oral antibiotics? Yes/No	7. Does your facility have PT/OT services? Yes/No	8. If yes, please specify ☐ < 3 days a week ☐ > 3 days a week

9. Does your facility have access to lab services?

   Yes/No

10. Does your facility have access a wound nurse specialist?

    ☐ Yes
    ☐ No
    ☐ No, but plan to develop an access plan
    ☐ No, but NP/PA is wound care trained

11. Does your facility use telehealth services to access physician services for consults?

    Yes/No

12. If your program currently provides wound care, on average how many wound patients do you have a month?

    ☐ 1-5
    ☐ 6-10
    ☐ 11-15
    ☐ 16-20
    ☐ >20

13. To participate in this program, you will be requested to create a Tiger Team to oversee design and implementation of the program. Are you able to convene a Tiger Team that can include:

    - Medical Director
    - Administration Team Lead
    - Admission Team Member
    - Certified Recovery Specialist
    - Lead Clinical Nurse
    - Staff Trainer
    - Social Worker/Care Management

    Yes/No

14. Do you have a wound care policy?

    Yes/No

15. Does your wound care policy specify that a physician, nurse practitioner, or physician assistant will prescribe initial wound treatment on admission?

    ☐ Yes, MD
    ☐ Yes, NP/PA
    ☐ No
    ☐ N/A

16. Does your wound care policy specify that initial wound assessment will be completed by physician, nurse practitioner, physician assistant, or registered nurse?

    ☐ Yes, MD
    ☐ Yes, NP/PA
    ☐ Yes, RN
    ☐ Yes, Wound Specialist RN
    ☐ No
    ☐ N/A
    ☐ Other

17. Does your wound care policy specify nurse practitioners, physician assistant, registered nurses will perform on-going wound care assessments?

    Yes/No

18. Does your wound care policy specify steps for escalating wound deterioration to MD, PA, NP?

    Yes/No

19. Does your wound care policy address staff taking photos to document wound observations?

    Yes/No

20. If policy does specify use of photography in wound care, does it include guidance on obtaining patient consent?

    Yes/No

21. Does your wound care policy allow patients to perform their own wound care?

    ☐ Yes, independently
    ☐ Yes, staff observation
    ☐ No
    ☐ N/A

22. Do you have an infection control policy that addresses wound care?

    ☐ Yes
    ☐ No
    ☐ N/A

23. Where is wound care can be performed?

    ☐ Client room
    ☐ Dedicated treatment room
    ☐ Other
    ☐ N/A

24. Does your wound care or infection control policy address where wound care supplies are stored?

    Yes/No

25. Does your wound care or infection policy address where sharps should be stored?

Yes/No

26. Do you have access to obtain wound care supplies?

Yes/No

27. Do you have a formal wound care education program?

☐ Yes
☐ No
☐ N/A

28. If you do have a training program, how often is it repeated? Select all that apply.

☐ Annually
☐ Only on hire
☐ As needed
☐ N/A

29. How often is wound care competency performed? Select all that apply.

☐ Monthly
☐ Yearly
☐ As needed
☐ N/A

9. REFERENCES

1. PDPH. (2023, October 2). **Philadelphia Records More Than 1,400 Overdose Deaths in 2022; Deaths Among Black Residents Rose Nearly 20%** (Press release).

2. Pennsylvania Department of Drug and Alcohol Programs (DDAP). **ASAM 3.7 Medically Monitored Intensive Inpatient Services by Service Characteristics**. 2020. Last accessed 7/10/2024.

10. ACKNOWLEDGEMENTS

Gratitude is extended to all individuals and teams whose efforts contributed to the preparation of this guide. Special recognition is given to the subject matter experts, writers, and reviewers who ensured the accuracy and clarity of the information presented. Appreciation is also given to users and testers whose feedback helped improve the quality and usability of this toolkit.

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APPENDIX A: ASAM 3.7 WOUND CARE PROGRAM PROJECT CHECKLIST

	Task	Target Date	Date Completed
1	Preliminary tour with consultants for present state		
2	Tiger team identified including: ➡ Medical Director ➡ Administration team lead ➡ Admission team member ➡ Certified Recovery Specialist ➡ Lead Clinical Nurse ➡ Staff trainer ➡ Social worker/care management (optional)		
3	Weekly meetings scheduled with DBHIDS/CBH team		
4	Complete DBHIDS 3.7 Wound Care Readiness Assessment		
5	Wound care policy and procedures reviewed and/or developed, including infection prevention principles (Minimum to include Appendix B)		
6	Pain management policy and procedures reviewed (and/or developed)		
7	MOUD induction, titration, and maintenance policy and procedures reviewed and/or developed		
8	Confirm unit(s)/area(s) where program will be located		
9	Develop wound care supply list (see Appendix C)		
10	Identify wound care supply housing		
11	Identify area for dressing changes		
12	Secure supplies for wound care, plan to use for training		
13	Develop training plan (who, what, where, when, and certification/sign off with annual competency) (See Appendices D and E)		
14	Determine if outside support/SME needed and engage		
15	Develop training program curriculum and mode (e.g., in-person, web-based, combination)		

	Task	Target Date	Date Completed
16	Schedule staff training, consider staged approach		
17	Schedule walkthrough prior to training		
18	Hold first training sessions		
19	Refine training with staff feedback		
20	Finish staff training		
21	Complete staff sign-off		
22	Complete DBHIDS 3.7 Wound Care Program Attestation		
23	Consider communication to referral sources 3.7 Wound Care Program is live		
24	DBHIDS to notify CBH that program is "3.7 Wound Care Program" approved for receiving referrals		
25	Weekly meetings will continue for at least the first month to discuss challenges followed by monthly meetings for 5 more months and quarterly thereafter.		

APPENDIX B: EXAMPLE WOUND CARE POLICIES AND PROCEDURES

Wound Care Policy [1,2]

Policy Statement

[FACILITY NAME] is committed to providing consistent, evidence-based quality care in managing and treating wounds for all patients. This will incorporate a holistic assessment and demonstrate patient involvement in the care provided.

Scope

This policy applies to all employed clinical staff involved in the direct care and observation of patients with wounds.

Aim

The aim is to provide consistent, individualized, high-quality wound management care for all patients/clients of [FACILITY NAME].

Objectives

The objective is to establish continuity of care for wound management across the recovery continuum.

Responsibilities

All-Staff Responsibilities

All staff must recognize and acknowledge their accountability to maintain and improve their knowledge and assist others within the care team to develop professional competence by:

- Adhering to the policy
- Completing training as required by [FACILITY NAME]
- Identifying and seeking training to address any personal competency, knowledge, and skill issues
- Actively participating in individualized treatment plans

Registered Nurse (RN)

- Identifying patients with wounds and documenting holistic assessments

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[1] *Adapted from: **NHS Foundation Trust, Ashford and St. Peter's Hospital. (2018) Wound Care Policy.** Last accessed 7/10/2024.*

[2] *Adapted from: National Alliance of Wound Care and Ostomy. **Scope of Practice**.*

- Liaising with the patient and the multidisciplinary team to formulate strategies and interventions to manage/treat wounds
- Ensuring that individualized, patient-focused care plans are in place and interventions are recorded, dated, and signed in line with facility documentation standards
- Providing patient education in support of patient-independent wound care
- Escalating wound care concerns to the physician when appropriate while maintaining the ongoing responsibility for patients' episodes of care

Licensed Practical Nurse (LPN)

- Making, reporting, and documenting observations about patient wounds in the medical record
- Escalating concerns to RN or physician per facility policy
- Providing direct wound care per physician's order
- Participating in educating patients about wound care

Program Directors

- Ensuring all appropriate staff are aware of this policy
- Ensuring this policy is implemented in proper treatment areas
- Ensuring that staff understand their accountability and responsibility and comply with this policy
- Ensuring that staff have the knowledge, skills, and competence commensurate with their roles and responsibilities to care for patients with wounds
- Ensuring staff have access to training commensurate with their roles and responsibilities
- Ensuring that needed wound care medications and supplies are available to staff and residents

Medical Directors and Consultants

- Ensuring that all relevant medical staff are aware of this policy
- Ensuring compliance with this policy within their areas of responsibility
- (Medical Director) Approving all wound care policies and procedures
- Partnering with care teams to ensure the most up-to-date wound care best practices are being implemented at all times

Principles of Assessment and Evaluation

The purpose of assessment is to record baseline information regarding the wound and patient and allow the appropriate practitioner to make clinical judgments and treatment decisions based upon it. The assessment also acts as a means of identifying and recording changes in the wound. The purpose of wound assessment is to obtain baseline information with which to produce a treatment plan.

Wound Photography (OPTIONAL)

Wound photographs are a useful visual record of wounds that are difficult to trace or measure and that may be large, deep, or irregular in shape. Patient consent must be gained prior to wound photography and documented on the appropriate facility consent form. Patients may wish to take photographs of their wounds

on their digital devices as a means of personal record keeping, and staff can assist with this where necessary. Care team members must follow all policies and procedures related to patient identification, storage, and transmission of photography.

Infection Control in Wound Management

Staff will follow facility infection prevention guidelines in using personal protective equipment and disposing of soiled wound care-related supplies per this policy.

Wound Care Policy and Procedure: Assessment, Treatment, and Documentation [3]

Policy Statement

To provide wound care treatments/services using a care team approach based on evidence-based standards of care under the direction of a physician/wound care specialist

Procedure

Initial Assessment

1. A qualified registered nurse (RN) or medical provider will assess wound(s) as part of the comprehensive initial assessment within 24 hours of admission and will document all clinical findings per [FACILITY NAME] policy.

2. All patients with a wound(s) will have their pain assessed as part of the wound care and receive analgesia as appropriate per the pain management policy.

3. Patients are also assessed for risk factors for further skin breakdown.

4. The admitting clinician will document each wound's status, including its location and etiology; measurement of length, width, and depth; undermining and tunneling, if present; description of the wound bed, drainage; signs and symptoms of infection, healing, and peri-wound skin condition and pain.

5. Each wound should be documented based on location and completed at each dressing change.

6. *Optional:* Each wound will be photographed digitally, ensuring proper HIPAA compliance and digital encryption to send electronically.

7. The RN or medical provider, in conjunction with the patient, will develop an appropriate plan of care based on the patient's needs and the assessment findings. Each patient will be evaluated and treated using an individualized care plan based on the patient's unique medical condition.

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[3] *Adapted from:* ***Connecticut Association for Healthcare at Home Wound Care Policy****. Last Accessed 07/13/2024.*

8. Patients are expected to participate in the plan of care, including active participation in wound care.

9. The clinician will provide wound care instruction and self-management education to the patient during wound care.

Continued/Ongoing Treatment

1. An RN or licensed practical nurse (LPN) will provide wound care per physician orders and continue to implement and evaluate the plan of care based on the effectiveness of the treatment regimen, response to treatment, the efficacy of interdisciplinary services, need for assessment by the RN patient participation, and identification of obstacles/risk factors interfering with wound healing. The RN/LPN will notify the physician of any change in the patient's condition or lack of progress.

2. At each dressing change, the wound will be observed, and documentation will include a description of the wound bed, drainage, signs and symptoms of infection, healing, and periwound skin condition. A complete set of vital signs, including temperature, will also be included.

3. At least every week, the wound assessment by an RN or physician/nurse practitioner and documentation in the medical record will include measurement of length, width, depth, and undermining and tunneling, if present.

4. All staff (NP/RN/LPN) providing direct patient care will document findings in the electronic medical record.

5. *Optional:* Wound digital images are adjunct to electronic/written documentation.

6. If the patient is not responding to the established treatment regimen, the RN/LPN shall evaluate for:

    - Need for treatment change
    - Referral to a medical provider or specialist for wound assessment
    - Need for plan of care reassessment due to non-healing wounds or increased complexity

7. Medical social workers, certified recovery specialists (CRSs), and counseling staff provide assessment and treatment of psychological, social, and financial factors impacting the progression of the plan of care.

Staff Education and Competency Testing

1. Newly hired RNs and LPNs will attend classes on skin and wound care. Topics will include assessment, determining wound etiology, documentation, product selection and use, and wound care techniques.

2. All nursing staff will complete competency assessments for basic wound care.

3. All care team members involved with wound care will receive annual training/competency to support continual advancement in best practice assessment and treatment in wound management.

4. Additional education will be provided as needed.

Evaluation

1. The ASAM 3.7 Wound Care Program will be evaluated annually to review compliance with agency policies and standards of care.

2. Clinical record documentation will be audited to identify staff education needs and patient care trends and evaluate the program's adequacy and effectiveness.

Wound Care Procedure: Wound Swab Cultures [4]

Purpose

To isolate and identify microorganisms causing an infection of the wound and identify the antibiotic(s) that should be effective in destroying the organism(s)

Procedure

1. Obtain the provider's order for wound swab cultures.

2. Conduct positive identification of residents per [FACILITY NAME] policy.

3. Prepare a clean work surface with a disinfectant wipe following the manufacturer's guidelines. Allow sufficient drying time. Put down a surface barrier (e.g., Chux pad).

4. Ensure all necessary supplies are assembled and arranged for cleaning the wound, obtaining a specimen, and redressing the wound. Place supplies on the surface barrier in an aseptic manner. Check that all items are in date and that the packaging is intact.

5. Perform hand hygiene and don clean gloves. Consider the use of surgical masks for all wound care.

6. Remove wound dressing. Dispose of gloves and dressing. Perform hand hygiene.

7. Don clean gloves. Rinse wound(s) with normal saline. Gently wipe excess saline with a sterile gauze pad.

8. Remove soiled gloves, perform hand hygiene, and don clean gloves.

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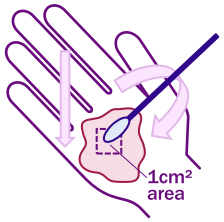
[4] *Source: **Pennsylvania Department of Health. "How to Collect a Wound Culture."** Last accessed 7/13/2024.*

Wound Culture (using the aseptic non-touch technique)

9. Aseptically pour a small amount of normal saline over the cotton swab to moisten it.

10. Levine Technique is recommended for culture collection: Identify 1cm^2 of clean wound tissue. Rotate the applicator for five seconds while applying enough pressure to produce fluid from the wound tissue.

    Please Note: *Do not take specimens from exudate, eschar, or necrotic material, and do not let the sterile swab touch gloves or other objects.*



11. Insert the swab immediately into a sterile container. Avoid contaminating specimens.

Wound Dressing

12. Doff gloves. Perform hand hygiene and put on clean or sterile gloves appropriate for the technique required to complete the dressing change.

13. Perform dressing change using the aseptic non-touch technique.

14. Dispose of materials as appropriate. Doff gloves and perform hand hygiene. Don clean gloves.

Specimen Handling

15. Label the specimen collection tube with the patient's name, date of birth, source, and collection date.

16. Place specimen in biohazard transport bag. Clean work surface. Perform hand hygiene.

17. Refrigerate specimens until ready for packaging and shipping.

Wound Care Policy and Procedure: Non-Sterile Wound Cleansing and Dressing [5]

Policy Statement

Wound dressings require a provider order and are performed by clinical staff with appropriately documented competency assessments if allowed by state scope of practice laws.

Purpose

To guide clinical staff to remove, clean, and apply wound dressings

[5] *Adapted from:* ***Pennsylvania Department of Health. How to Collect a Wound Culture; Wound Care Observation Checklist for Infection Control****. Last accessed 7/13/2024.*

Procedure

1. Review provider order for wound dressing. The provider order should contain the following elements:
    - wound location
    - cleansing solution
    - primary dressing/wound care product
    - secondary dressing/wound care product, if applicable
    - frequency of dressing changes
2. Positively identify the resident using approved identifiers per [FACILITY NAME] policy.
3. If not using a treatment room, provide privacy for the resident while performing a dressing change.
4. If required, provide pain management per [FACILITY NAME] policy.
5. Prepare a clean work surface with a disinfectant wipe following the manufacturer's guidelines. Allow sufficient drying time. Put down a surface barrier (e.g., Chux pad).
6. Ensure all necessary supplies are assembled and arranged for cleaning the wound, obtaining a specimen, and redressing the wound. Place supplies on the surface barrier in an aseptic manner. Check that all items are in date and that the packaging is intact. Note: Products labeled "single patient use" will be used on only one resident.
7. Perform hand hygiene per [FACILITY NAME] policy and don clean gloves. Consider using a surgical mask for all dressing changes.
8. Place absorbent, protective underpads under the area to be dressed.
9. Carefully remove old dressing (many microorganisms are shed into the air) and discard it per hospital policy. Limit wound exposure to prevent airborne contamination.
10. If the dressing has multiple layers, cut one layer at a time, avoiding letting the scissors contact the skin.

    Note: *Use bandage scissors, which are designed to remove dressings with less harm to the patient. The scissors are characterized by a flat plate (knob) for slipping under the bandages.*

11. Remove and discard gloves. Perform hand hygiene per [FACILITY NAME] policy. Don another set of gloves.
12. Assess wound(s) and notify the provider of any concerns (e.g., odor, drainage). An RN/medical provider does assessments. Observations of wounds by LPN staff should be documented per [FACILITY NAME] policy. LPNs are to escalate any concerning observations to the RN/medical provider.

13. Irrigate wound(s) with an ordered solution and dry peripheral skin if ordered. Ensure the solution is at least room temperature.
    - » Be careful to prevent cross-contamination between multiple wounds.
    - » Use a syringe with a catheter tip or other irrigation method with gentle pressure.
    - » A non-cytoxic wound cleanser/irrigant may also be used per medical provider order.
14. If ordered, cleanse wound(s) with normal saline or other ordered solution using wound cleansing technique.
    - » Wound cleansing technique for linear wound:
        - Moisten a gauze pad with a cleaning agent.
        - Wipe the wound from top to bottom and work outward.
        - Wipe from the clean area toward the less clean area.
        - Use a new swab or pad for each downward stroke.
        - Repeat for each wound using a new moistened gauze pad. Be careful to prevent cross-contamination with multiple wounds.
    - » Wound cleansing technique for open wound(s):
        - Moisten a gauze pad with a cleansing agent.
        - Clean the wound in full or half circles, beginning in the center and working toward the outside.
        - Use a new gauze pad for each circle.
15. Repeat for each wound using a new moistened gauze pad. Be careful to prevent cross-contamination with multiple wounds.
16. Dry surrounding tissue with a gauze pad.
17. Reassess wound(s) (RN/medical provider does assessments).
    - » Notify the provider of any concerns (e.g., odor, drainage).
    - » Measure wound(s) and record per policy.
    - » Photograph and record the wound per [FACILITY NAME] policy (OPTIONAL).
    - » Determine whether wound regression or progression requires changing the original dressing order.
        - Obtain provider order per [FACILITY NAME] policy.
18. Doff and discard gloves, perform hand hygiene per [FACILITY NAME] policy, and don another set of clean gloves.
19. Apply primary dressing/wound care product per Medical Provider order.

- » If the provider has ordered a topical medication to be applied to the wound, only an RN or LPN may apply it.
- » Keep dressings within the wound margins and do not overlap with intact skin unless recommended by the manufacturer.

20. Apply secondary dressing, if ordered by the provider, per manufacturer's guidelines.
    - » Attempt to avoid adhesive contact with skin. When this cannot be avoided, utilize hypoallergenic tape and a protective film barrier.
21. Discard all waste materials and single-use supplies.
22. Remove and discard gloves.
23. Perform hand hygiene per [FACILITY NAME] policy.
24. Educate resident on dressing (primary and/or secondary) at initial application and as needed with subsequent dressing changes.
25. Document any dressing change, wound assessment, and resident education.
26. Clean the work surface with hospital-approved disinfectant.
27. Any unused products shall be discarded per FACILITY NAME policy. Some products may require disposal as biohazard waste.

APPENDIX C: WOUND CARE SUPPLY LIST

Wound care providers use several supplies to promote healing by cleaning, treating, and protecting wounds. These range from over-the-counter dressings and ointments to prescription topical therapies for cleaning, decreasing bacterial burden and supporting debridement. The selection of wound care supplies can depend on available resources, training, and individualized clinical decision-making. The table below describes wound care supplies commonly used in caring for individuals with xylazine-associated wounds.

Please Note: *Facility to modify based on physician-approved protocols.*

Supplies for Xylazine-Associated Wounds [6]			
Supply	**Description/Note**	**Pros/Cons**	**Rx Required?**
Cleansing *(supplies used to clean wound bed, periwound, and surrounding skin)*			
Woven Gauze	4x4 cotton surgical sponge	➡ Textured gauze that cleans more effectively ➡ Should not be used as a contact dressing because can stick to wound bed and cause trauma with removal	No
Potable Tap Water	Well-tolerated cleanser	➡ Readily available to housed residents ➡ Not always available to unhoused residents	No
Normal Saline	Fluid solution that is 0.9% sodium chloride	➡ Readily available and well tolerated	No
Wound Cleanser (e.g., Skintegrity™)	Rinsing solutions	➡ Somewhat reduces bioburden, nontoxic to human cells ➡ May sting	No
Vashe™	Nontoxic to human cells	➡ Reduces bioburden and odor ➡ Expensive	No
Quarter Strength Dakins Solution™ (0.125%)	Diluted sodium hypochlorite (e.g., bleach)	➡ Reduces bioburden and odor ➡ May sting, limited toxicity to human cells, do not mix with ammonia	No
Contact Dressings *(primary dressings placed directly on the wound bed)*			
Oil Emulsion (e.g., Adaptic™)	Nonocclusive (allows drainage to pass through to an absorbent dressing),	➡ Limited sticking to wound bed	No

[6] *Source: PDPH. Recommendations for Caring for Individuals with Xylazine-Associated Wounds. January 8, 2024.*

Supplies for Xylazine-Associated Wounds [6]

Supply	Description/Note	Pros/Cons	Rx Required?
	nonadherent fabric mesh in oil	➡ allows drainage to pass through to absorbent layer	
Nonadherent Pads (e.g., Telfa™)	Nonwoven cotton/ polyester with nonstick layer (contact and/or absorbent)	➡ Limited sticking to wound bed ➡ Absorbs light drainage ➡ Inexpensive	No
Occlusive Petrolatum (e.g., Xeroform™)	Occlusive (not permeable by air and liquid) finewoven fabric in petrolatum and bismuth	➡ Limited sticking to wound bed ➡ Some antimicrobial properties ➡ Promotes autolytic debridement ➡ Caution with maceration ➡ Don't use with iodine allergy	No
Alginate, Carboxymethylcellulose (CMC) Absorptive Dressing	Turn from dry to gel, use only with heavy drainage	➡ Absorbs heavy drainage ➡ Promotes autolytic debridement ➡ Has antimicrobial properties when imbued with silver ➡ Expensive	No
Absorbent Dressings *(secondary dressings placed on top of contact layer to soak up wound exudate and provide protection to the wound)*			
Foam	Bordered or non-bordered (contact and/or absorbent)	➡ Gentle ➡ Limited sticking to wound bed ➡ Asorbs light to heavy drainage ➡ Cushions from pressure or shear force (e.g., feet)	No
Abdominal (ABD) Pad	Gauze pads with an absorbent layer, recommend use with contact layer dressing	➡ Absorbs moderate to heavy drainage ➡ Provides cushioning ➡ Inexpensive	No
Super Absorb Pad	Gauze pads with a layer of superabsorbent polymer	➡ Locks in heavy drainage away from the wound ➡ Can be bulky ➡ Expensive	No
Supportive Dressings *(keep the contact and supportive dressings in place, augment durability, and protect the wound from the external environment and prevent wound drainage from reaching clothing)*			
Rolled Gauze	Elastic or Kerlix	➡ Breathable	No

Supplies for Xylazine-Associated Wounds [6]

Supply	Description/Note	Pros/Cons	Rx Required?
Self-adhesive Wrap (e.g., COBAN™)	Self-adhering	➡ Protects bandage from environment, and clothes from drainage ➡ Can seal in moisture ➡ Use with caution as can cause a torniquet effect with tight wrapping	No
Elastic Bandage	Ace wrap	➡ Protective, somewhat breathable ➡ Can be easily adjusted and reused	No
Retention Netting (e.g., Tubigrip™)	Cloth sleeve	➡ Most breathable ➡ Can unwrap then rewrap	No
Periwound Barriers *(ointment and film agents used to protect the periwound area from drainage that can cause maceration, or skin softened by persistent exposure to fluids (e.g., wound drainage)*			
A&D	Petrolatum + vitamins A and D	➡ Donates some moisture as it protects ➡ Vitamins for tissue repair ➡ Inexpensive	No
Dimethicone	Primarily dimethicone often with other ingredients	➡ Donates less moisture	No
Zinc (e.g., Triad™)	Primarily zinc often with other ingredients	➡ Zinc improves tissue repair and is somewhat antimicrobial ➡ Donates minimal moisture	No
No-Sting Skin Prep (e.g., Cavilon™)	Film barrier (some skin prep does not protect against drainage)	➡ Good drainage protection ➡ Increases adhesion for border dressings and band-aids ➡ Donates minimal moisture	No
Topicals *(agents such as ointments and gels used directly on the wound bed and surrounding skin to promote healing and prevent infection)*			
Petrolatum-based Ointment (e.g., A&D, Vaseline™, Aquaphor™)	Not antimicrobial but helps prevent bacterial colonization	➡ Keeps wound moist ➡ Somewhat promotes autolytic debridement ➡ Inexpensive	No
Medihoney™	Leptospermum Manuka medical grade honey, antimicrobial	➡ Promotes moisture ➡ Generally antimicrobial (acidic, low pH), anti-inflammatory, nontoxic to human cells ➡ Promotes debridement ➡ Expensive	No

Supplies for Xylazine-Associated Wounds [6]			
Supply	**Description/Note**	**Pros/Cons**	**Rx Required?**
		➡ Caution when applying in hotter months as many unsheltered residents are often bothered by flies and maggots	
Polyhexamethylene Biguanide (PHMB)	Antimicrobial, in petrolatum or hydrogel base, or imbued into dressings	➡ Broad spectrum antimicrobial (including against *Methicillin-resistant staphylococcus aureus* [MRSA], *Vancomycin-resistant Enterococcus*, *E. coli*, *Pseudomonas*) ➡ Nontoxic to human cells ➡ Base determines if helps with debridement (hydrogel > petrolatum) ➡ Stays active for several days ➡ Expensive	No
Silver Hydrogel (e.g., Silvasorb™)	Antimicrobial	➡ Broad spectrum antimicrobial (including against MRSA, *E. coli*, *Pseudomonas*) ➡ Gel base aids debridement ➡ Stays active and noncytotoxic for several days ➡ Expensive ➡ Don't use with collagenase	No
Silver Sulfadiazine (Silvadene™)	Antimicrobial used in burn wounds to prevent infection	➡ Broad spectrum antimicrobial (including against MRSA, *E. coli*, *Pseudomonas*) ➡ Nontoxic to human cells ➡ Petrolatum base can aid debridement ➡ Stays active for several days ➡ Should not be used with collagenase or on residents who have a sulfa allergy	Yes
Mupirocin	Antibiotic in petrolatum	➡ Antimicrobial (including against MRSA, *Streptococcus*)	Yes
Collagenase (Santyl™)	Enzymatic debriding agent	➡ Breaks down dead tissue ➡ Doesn't harm healthy tissue ➡ Requires daily dressing changes ➡ Has short duration of activity ➡ Very expensive ➡ Inactive at low pH (e.g., acidic) that can be caused by other products (e.g., Medihoney)	Yes

Supply Considerations for ASAM 3.7 Wound Care [7,8]

(from least expensive to more expensive, not brand-specific)

Cost	Clean	Contact Layer	Absorbent Layer	Securement
$	Water and soap	Petroleum	ABD pad	Gauze roll
↕	Normal saline	No-sting barrier	Silicone foam-bordered dressing (absorbent and securing)	Athletic or Ace wrap
↕	Mild foam cleanser	Antibiotic ointment	Super absorbent dressing (absorbent and securing)	Tubular elastic dressing
↕	Sodium hypochlorite cleanser	Skin barrier cream		
↕	Hypochlorous acid cleanser	Medihoney		
$$$		Hydrophilic zinc		
		Silver		

[7] *Adapted from: PDPH.* ***Caring for People with Xylazine-Associated Wounds: Recommendations and Lessons Learned from Wound Care Clinicians in Philadelphia*** *(Webinar). January 8, 2024.*

[8] ***WoundSource*** *(2018). The Kestrel Wound Product Sourcebook (WoundSource). Kestrel Health Information, Inc.*

APPENDIX D: EXAMPLE WOUND CARE STAFF EDUCATION PROGRAM

Primary Focus of the Program

Provide an independent assessment of the knowledge, skills, and/or competencies required for competent performance of wound assessment and topical treatment.

Training Plan for Staff Caring for Individuals with Xylazine Wounds

Understanding the Population

Overview of Substance Use Disorder (SUD)

Provide an overview of SUD, its prevalence, and common substances of misuse.

Challenges Faced

Discuss the challenges individuals with SUD may face, such as stigma, healthcare access barriers, and co-occurring health issues.

Introduction to Xylazine and Its Effects

Definition and Characteristics

Explain what xylazine is, its veterinary use, and its misuse among individuals with substance use disorder (SUD).

Impact on Wounds

Discuss the specific effects of xylazine on wounds, including tissue necrosis, infection risk, and complications.

Recognizing Xylazine Wounds

Identifying Symptoms

Train staff to recognize symptoms of xylazine-related wounds, such as discoloration, pain, swelling, and signs of infection.

Cultural Sensitivity

Emphasize the importance of cultural sensitivity and non-judgmental attitudes in providing care to individuals with SUD.

Initial Assessment (RN, NP, and MD) and Documentation

Assessment Procedures

Conduct a thorough assessment of xylazine wounds, including visual inspection, palpation, and documentation of wound characteristics.

Documenting History

Stress the importance of documenting any history of substance use and previous treatments.

Ongoing Wound Observation

Stress the importance of ongoing wound observations and when to escalate concerns to the provider(s).

Cleaning and Dressing Techniques

Cleaning Procedures

Demonstrate proper wound-cleaning techniques using sterile saline and gentle irrigation to avoid further tissue damage.

Dressing Application

Provide hands-on training on selecting and applying appropriate dressings based on wound characteristics and resident comfort.

Steps in Performing a Dressing Change

Antiseptic Use

Educate staff on using antiseptic solutions (e.g., chlorhexidine) to reduce infection risk.

Monitoring for Infection

Discuss signs of wound infection and when to escalate care or seek medical assistance.

Monitoring Schedule

Establish a schedule for regular wound assessment and documentation of healing progress as directed by a medical provider.

Review and Feedback

Feedback Sessions

Schedule regular feedback sessions to discuss staff experiences, challenges encountered, and opportunities for improvement.

Continuous Learning

Encourage staff to stay updated on best practices in wound care and substance use treatment through continuing education opportunities.

Competency Assessment

Assess wound care practice competency interim, at least yearly.

Resources for Preparing the Above Training Program

- Centers for Disease Control (CDC). **Treatment of Substance Use Disorders**.
- PDPH. **Recommendations for Caring for Individuals with Xylazine-Associated Wounds**.
- NIH National Institute on Drug Abuse. **Xylazine**.
- McFadden R, Wallace-Keeshen S, Petrillo Straub K, Hosey RA, Neuschatz R, McNulty K, Thakrar AP. **Xylazine-associated Wounds: Clinical Experience From a Low-barrier Wound Care Clinic in Philadelphia**.
- National Association of County and City Health Officials (NACCHO). **Harm Reduction As A Trauma-Informed Approach To Substance Use: A Guide For Primary Care Providers**.
- Open Resources for Nursing (Open RN); Ernstmeyer K, Christman E, editors. Nursing Skills [Internet]. **Section 20.3. Assessing Wounds**.

Pennsylvania Department of Health. **Wound Care Observation Checklist for Infection Control**.

Sample Training Program

- DBHIDS. **Wound Care: The Clinician's Role in Providing Care**. *Presentation PowerPoint.*
- DBHIDS. **Caring for Wounds in ASAM 3.7: Post-test After Education**. *Microsoft Forms Quiz.*

Example Resident Wound Care Education

Introduction

Your physician has recommended that you have dressing changes to provide a moist healing environment for your wound. The following information lists what you should do to change your dressing. Read these instructions before you begin. It is ideal if you shower or bathe daily and perform your wound care at that time. If you have any questions, please call [REFERENCE NUMBER].

Gather Supplies

Wound cleanser,
sterile saline,
or soap and water

Packing strip

	4x4 and impregnated gauze pads		Antibacterial ointment
	Hydrogel		Tape
	Foam		Ace or self-adherent wrap

Follow These Steps

1. Wash hands.
2. Gently remove the old dressing and discard it in a plastic bag—seal the bag before placing it in the trash.
3. Rewash hands.
4. Clean the wound with wound cleanser, sterile saline, or soap and water. If you're in the shower, you can cleanse your wound using a net sponge with soap and water.
5. Apply dressing.
6. Rewash hands.
7. Change dressing every [TIME PERIOD].

If Any of the Following Occur, Go to the Treatment Center

- Fever
- Redness or swelling at the wound site
- Warmth at the wound site
- Increased or foul-smelling drainage from the wound

APPENDIX E: EXAMPLE WOUND CARE COMPETENCY OBSERVATION CHECKLIST

The following represent best practices for infection control during wound dressing changes, assessment, and care.[9] To evaluate wound practices after training, observe wound care procedures from start to finish, marking whether practices were appropriate (yes) or not (no) or not observed (n/a). Make notes of all deviations from best practices (areas for improvement).

Practices	Yes	No	N/A	Notes
1. All supplies gathered before dressing change ➡ Supplies were handled in a way to prevent contamination ➡ Supplies are dedicated to and labeled for one individual ➡ Multi-dose medications are used appropriately[1]				
2. Hand hygiene performed properly before preparing clean field[2]				
3. Clean field prepared ➡ Surface cleaned with antiseptic wipes following manufacturer guidelines ➡ Surface barrier applied (e.g., Chux pad) ➡ Supplies placed on surface barrier in aseptic manner				
4. Hand hygiene performed properly before starting the procedure				
5. Clean gloves and PPE donned according to Standard or Contact precautions ➡ Consider use of surgical mask for all wound care				
6. Barrier positioned under wound				
7. Old dressing removed and discarded immediately				
8. Dirty gloves removed and discarded[3]				

[9] *Source: Pennsylvania Department of Health. **Wound Care Observation Checklist for Infection Control**.*

Practices	Yes	No	N/A	Notes
9. Hand hygiene performed properly before accessing clean supplies[3]				
10. Clean gloves donned				
11. Wound cleaned using aseptic non-touch technique[4]				
12. Wound treatment completed using aseptic non-touch technique[4]				
13. Dirty supplies discarded in trash receptacle				
14. Gloves removed and hand hygiene performed properly after dressing change is complete				
15. Reusable equipment cleaned and/or disinfected appropriately[5]				
16. Wound cart is clean and utilized appropriately[6]				

Rationale

1. Multi-dose wound care medications (e.g., ointments, creams) should be dedicated to a single resident whenever possible, or a small amount of medication should be aliquoted into a clean container for single-resident use. Medications should be stored in a centralized location and never enter a resident's room.

2. Proper hand hygiene is that which occurs at the right time, uses the proper method, and uses the correct technique and duration. Follow the **CDC Guideline for Hand Hygiene in Healthcare Settings**. Some notes to consider:

    - Alcohol-based hand rub (ABHR) is the preferred method of hand hygiene in health care settings and should always be used, except:
        - When hands are visibly soiled
        - After known or suspected exposure to Clostridium difficile (C. diff), if your facility is experiencing an outbreak or higher endemic rates
        - After known or suspected exposure to residents with infectious diarrhea during norovirus outbreaks
        - Before eating

- After using the restroom

» When using ABHR, cover all surfaces of your hands and rub your hands until they feel dry.

» When washing your hands with soap and water, rub your hands together vigorously for at least 20 seconds, covering all hand surfaces. Rinse hands with water, use disposable towels to dry, and turn off the faucet with a towel.

3. Gloves should be changed, and hand hygiene performed when moving from dirty to clean wound care activities (e.g., after removing soiled dressings, before handling clean supplies). Debridement or irrigation should be performed in a way that minimizes cross-contamination of surrounding surfaces from aerosolized irrigation solution.

4. Aseptic non-touch technique refers to a procedure that aims to prevent the transmission of microorganisms to the wound. Clean gloves should not directly come in contact with the wound bed. If the wound requires direct palpation, sterile gloves should be worn. Sterile applicators should be used to apply medications. Dressings should be handled in an aseptic manner so that staff hands or other surfaces never touch the dressing surface applied to the wound.

5. In addition to reusable medical equipment, any surface in the patient/resident's immediate care area contaminated during a dressing change should be cleaned and disinfected. Any visible blood or body fluid should be removed with a wet, soapy cloth and then disinfected with an EPA-registered disinfectant per manufacturer instructions and facility policy. Surfaces/equipment should be visibly saturated with solution and allowed to dry for proper disinfection before reuse.

6. Wound care supply carts should never enter the patient/resident's immediate care area or be accessed while wearing gloves or without performing hand hygiene first. This is important for preventing cross-contamination of clean supplies and reiterates the importance of collecting all supplies before beginning wound care.

APPENDIX F: EXAMPLE WOUND PHOTOGRAPHY POLICY AND PROCEDURE (OPTIONAL)

Should service providers choose to utilize wound photos as part of the referral process, these photos, including transmission and storage of images, must have documented policies and procedures related to resident identification, consent for photography, and transmission of photos. Consult facility administrator and/or legal consultant.

Purpose

To describe the process used to create and store digital photographic documentation of wounds evaluated and treated by [FACILITY NAME]

Policy Statement

Digital wound photography is an important adjunct to written documentation of the evaluation and treatment of wounds at [FACILITY NAME]. Wounds should be photographed at the discretion of the clinician caring for the resident after obtaining written consent to photograph. (See **Attachment**: "Consent to Photograph for Resident Care and Medical Record Purposes.") Only the [FACILITY NAME]-owned digital camera may be used for wound photography.

Supplies/Equipment Needed

- Digital camera
- White label/measuring guide (in centimeters) upon which the clinician is to write the following in black ink:
  - the date
  - resident initials or resident ID #
  - location of the wound
  - if there are multiple wounds, the number of the wound
- Blue or other dark pad, towel, or other dark cloth to provide a monochromatic background for the photograph

Procedure

1. Witness the resident's consent to wound photography. Document any refusal of wound photography and the reason in the clinical note on the day of refusal.

2. Position the resident comfortably so the wound can be easily seen through the digital camera's viewfinder.

3. Place a blue or similar solid-colored pad, towel, or background material under the area to be photographed.

4. Adjacent to the wound, place or hold an identification tag (label/measuring guide noted in supplies/equipment above) on which the date, resident initials, resident's ID#, wound location, and wound number are printed in black ink.

5. Do not use a camera's auto-date stamp as a label since this provides incomplete and potentially incorrect information.

6. Take the photograph as follows:

    - Point the lens directly at the wound so the view is taken straight at a 90-degree angle. Use auto flash.
    - Use the same position, angle, and perspective each time the wound is photographed. If necessary, refer to the initial photograph for proper orientation.
    - Use appropriate magnification for the size of the wound.

7. Use the same magnification each time the wound is photographed unless the wound size increases.

8. Take several photos of each wound, compare quality, and select the best image.

9. For multiple wounds, take a reference photograph of the area, then individually photograph and label each wound using magnification appropriate for each wound size.

10. For circumferential wounds, take a reference photograph of the area, then photograph and label the following wound aspects:

    - Anterior
    - Lateral
    - Posterior
    - Medial

11. Document the existence of digital wound photographs by placing a call log in the resident's electronic medical record.

12. Wound photographs will be processed, downloaded, and stored in a designated electronic file in medical records.

13. Wound photographs are NOT to be sent electronically or to other entities without the authorization of the Medical Records.

Attachment: Consent to Photograph for Resident Care and Medical Record Purposes

Please Note: *Sample form only. Consult facility administrator and/or legal consultant.*

Resident Name:	
ID #:	

Consent to Photograph for Resident Care and Medical Record Purposes

In the interest of documenting resident progress within the treatment program and to assist in the diagnosis and treatment rendered to me by [FACILITY NAME], I agree to have my wound(s) digitally photographed and electronically stored in my medical record.

I understand that I will be photographed by [FACILITY NAME] staff or others approved by [FACILITY NAME] and with the agreement of my physician. I understand I will not be reimbursed for the photos. I understand that in addition to documenting my care, the [FACILITY NAME] staff may also use these photographs to educate [FACILITY NAME] staff in the treatment of similar conditions.

☐ Wound care photographs will be taken to document the status of my wounds.

☐ I agree to allow my photographs to be used in the community education efforts of [FACILITY NAME].

☐ I agree to allow my photographs to be used in the professional education efforts of [FACILITY NAME] and the product manufacturer.

I agree to be photographed as described and identified above. I understand that [FACILITY NAME] will keep these as part of my confidential medical record. I may obtain copies of these photographs through the medical record department in keeping with [FACILITY NAME] procedures. A fee may be charged for copies.

Resident/Legal Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

THIS FORM MUST BE FILED IN MEDICAL RECORD