1.0 PURPOSE:

1.1 To avoid introducing new microorganisms into an existing wound.

1.2 To provide safe, cost effective wound care.

1.3 To avoid cross contamination of microorganisms between residents in a personal care home (PCH).

1.4 To protect PCH health care providers from exposure to body fluids that may be present during wound care procedures.

2.0 DEFINITIONS:

2.1 Immunocompromised: Individuals whose immune mechanisms are deficient because of immunologic disorders. This generally refers to immunosuppressive therapy [e.g. radiation, cytotoxic chemotherapy, anti-graft rejection medication, steroids].

2.2 Sterile Technique: Involves activities to eliminate exposure to microorganisms and maintain objects and areas as free from microorganisms as possible. Sterile technique involves meticulous hand hygiene, use of a sterile field and sterile gloves, wound cleanser, individually packaged sterile dressings and instruments or a sterile dressing tray.

2.3 Clean No-touch Technique: Involves activities to reduce the overall number of microorganisms or to prevent/reduce the risk of transmission of microorganisms from person-to-person or from place-to-place. Clean technique involves meticulous hand hygiene, use of a clean field, clean gloves, clean *dressings and instruments. Sterile saline or commercially prepared cleanser is used for wound cleansing.
“No touch technique” is a technique of changing surface dressings without directly touching the wound or any surface that might come in contact with it.

- Clean dressings – dressings originally packaged as sterile

2.3 Localized infection: presence of bacteria in a wound in numbers that disrupt healing and damage wound tissues. Signs may include erythema, edema, purulent discharge, malodour, and increase in wound size

2.4 Spreading Infection: Bacteria numbers have increased beyond a local infection. Signs and symptoms may include spreading erythema greater than 2cm from wound margin, induration of regional tissues, fever, spreading edema, malaise and delirium.

3.0 OPERATIONAL DIRECTIVES:

3.1 Clean no-touch technique shall be used for wound care except in situations as outlined in 3.2.

3.2 Sterile technique shall be used in the following circumstances:

3.2.1 The resident is immunocompromised.

3.2.2 The resident experiences recurrent localized or spreading wound infections.

3.2.3 The resident has a wound that enters a sterile body cavity (e.g. nephrostomy tube or sinus into a joint capsule).

3.2.4 With sharp, conservative wound debridement.

3.2.5 Any other condition that compromises the ability to maintain an acceptable clean healing environment.

3.2.6 For surgical incision dressings up to 48 hours postoperatively.

3.3 Any device used to clean or irrigate wounds (i.e., commercially prepared wound cleanser spray bottles, syringes with venous access devices, etc.), shall not be used between residents due to potential for cross-contamination. Disposable products such as syringes, etc., shall be discarded weekly or as necessary if soiled. Commercial products shall be discarded as per expiry date.

3.4 Reusable instruments must be cleaned thoroughly and reprocessed, as per manufacturer’s instructions, between each resident use.

3.5 Unused contents of normal saline shall be discarded after each use.

4.0 PROCEDURE:

4.1 Explain procedure to resident prior to initiation of care. Offer analgesics as required.
4.2 Use appropriate hand hygiene and personal protective equipment as per Routine Practices when providing wound care.

4.3 Wear clean gloves for anticipated contact with blood, wound fluid and non-intact skin. If gloves become visibly contaminated during the removal of soiled dressings, remove them, perform hand hygiene and put on clean gloves before applying the new dressing. Gloves may not be needed if the wound is dry or skin is intact. If gloves are used, perform hand hygiene immediately after removal.

4.4 When treating multiple ulcers on the same resident, attend to clean areas before the more contaminated areas (i.e. sacral, peri-anal area).

4.5 Decide on the necessary wound care technique i.e.: sterile versus clean no-touch, after an individual assessment of the resident care situation has been completed and wound healing goals have been determined.

4.6 Document the technique to be used on the wound care treatment plan.

4.7 If clean no - touch technique is to be used, follow the guidelines below:
   4.7.1 Store dressings and other supplies in the original packaging or in container such as a sterile specimen container.
   4.7.2 Prepare an individual “dressing kit” for each resident. Use a plastic container such as a resealable bag or box to store dressings, pastes, gels, wound cleansers, gloves, scissors, instruments and other required supplies.
   4.7.3 Take the resident’s “dressing kit” to the bedside. The multi-treatment cart/basket should not be taken into the room.
   4.7.4 Caregivers must perform hand hygiene before contact with clean dressings or supplies.
   4.7.5 Prior to the dressing or treatment, remove from the container only the number/amount of clean dressing(s) necessary for the dressing change.
   4.7.6 Discard the entire package if it, or the dressing(s) contained within it becomes wet, contaminated or dirty.

4.8 When sterile technique is to be used, take only the necessary supplies to the bedside (i.e. sterile tray, wound cleanser, sterile dressings and other required supplies).

4.9 When cleansing a wound with a spray applicator or syringe with an irrigation tip, hold the device 15-20cm (6-8”) from the wound to prevent contamination of the device and its contents.
4.10 When applying gels or pastes to the wound take care not to contaminate the contents of the container (i.e.: do not touch tip of tube or allow tip of tube to touch wound).

REFERENCES:


5.12 Winnipeg Regional Health Authority Regional Wound Care Recommendations, May, 2009


**Policy/Procedure Contact:** Betty Taylor, Manager, PCH Infection Prevention & Control

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