Catholic Charities Disabilities Services
Agency Procedure

Procedure Category	Nursing
Procedure Title	Wound Care
Regulations	
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Attachments	Braden Scale
Approved by: Melissa Krissel, Director of Residential Services - Clinical	

I. BACKGROUND

Wounds are more prevalent of a concern when working with people with intellectual or developmental disabilities that are either wheelchair bound, or unable to express themselves verbally. This is also true with individuals with a secondary diagnosis of Diabetes. Wounds can lead to infection and decrease quality of life; and severe enough can lead to much more significant medical complications.

II. POLICY

Catholic Charities Disabilities Services will evaluate skin integrity risk using the Braden Scale forms on every individual that is at risk for skin breakdown. This includes individuals that have reduced ability to ambulate and/or turn themselves in bed, or those that are completely unable to ambulate and/or turn themselves in bed.

III. PROCEDURES

1. Every individual admitted to an OPWDD Certified Site that has reduced capacity or no capacity to ambulate and/or turn themselves in bed, will have a Skin Integrity Assessment upon Admission and annually thereafter. This will consist of the Braden Scale Form that is appropriate for assessing the individuals we serve. This will be included in the individual's Life Plan, Plans of Nursing Services (PONS), Treatment and Hygiene documents, and Staff Action Plans as necessary.
2. All staff will be responsible for daily skin checks and report to the Program Nurse, Nursing Supervisor, or On-Call Nursing, any and all changes that are noted including approximate size, color and location of skin integrity concerns.
3. **Any individual that develops a wound**:
    - The Program RN, or Nursing Supervisor will assess the wound within 24 hours of or next business day from report. The wound will be measured and staged and documented in Therap. Instructions for staff to care for the wound (stage 2 or lower) will be documented on the MAR and in Therap. The Program RN, or Nursing Supervisor will also document initial findings in Therap.
    - Any individual that has a change in status will have an updated Plan of Nursing Services (PONS) to assist staff with knowing how to treat the wound.
    - The Program RN, or Nursing Supervisor will then re-assess the wound at least weekly, including measure and stage, and document in Therap. This will continue until the wound is fully healed. If the wound does not improve within a month, or becomes worse than a stage 2, or show signs or symptoms of infection, the individual will be sent to be seen by provider (either ER or PCP) immediately.
    - Any individual with a wound beyond stage 2, a licensed medical professional (RN, LPN, etc.) will treat the wound as order by provider.
    - All active wounds will be discussed at regularly scheduled Clinical Team meetings and documented in meeting notes.

IV. FORMS USED

Braden Scale Assessment Form