



STONEY HEALTH SERVICES POLICY AND PROCEDURES

SKIN & WOUND CARE MANAGEMENT POLICY

Effective: March 12,2015	Policy Code: PP + TITLE	Applies To:	<input type="checkbox"/> Leadership & Operations
Review: Feb. 24,2019	Sheet: 1 of 37		<input checked="" type="checkbox"/> Programs & Services
Next Revision: Feb. 24,2022	Approval: A. Khan, Executive Director		<input type="checkbox"/> Client, Family & Community

Related Polices & Procedures: SHS IPAC Policy; SHS Skin Suture, Clip & Staple Removal Policy

1. POLICSTANDARD: Stoney Health Services uses an interdisciplinary and collaborative approach to assess clients who need skin and wound care in order to provide client-centered, evidence-informed care that promotes healing and reduces morbidity and mortality. SHS, as per the First Nations & Inuit Home and Community Care Program (FNIHCCP) policy, adheres to the Alberta Health Services Wound Care Guidelines which promote best practices in wound care, including standards for the removal of non-viable tissue in wounds

2. RATIONALE: An estimated one-third of all home and community care clients require wound care. As the use of Home Care services increases with an aging population and shorter hospital stays, it is becoming increasingly important to have an evidence-based Skin and Wound Care program. Research shows that wound care protocols developed using evidence-informed guidelines not only lead to improved client outcomes but also to a reduction in healthcare costs.

SHS recognizes the importance of all members of the health care team having the knowledge and skills to contribute to not only the management of wounds but also to the prevention of wounds. E-learning modules on wounds, ostomies and continence care developed by experts with Health Canada have therefore been deemed mandatory education in the orientation process along with the annual Health Canada Dressing Formulary Update. In addition, when treating complex wounds that are often accompanied by co-morbid conditions, personnel of the SHS Home Care Program have access to an Enterostomal Therapist (ET) for further consultation.

3. POLICY: All staff of Stoney Health Services that provide wound care services will do so in accordance with the online Wound Assessment Case Studies online learning modules available at: <http://www.abnurse-elc.com/campus/> or via the OneHealth Portal , including the following procedures (on online learning modules).

4. PROCEDURES : This documents contains the following procedures :

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- B. Acute Wounds, p. 4
- C. Pressure Injuries, p.4
- D. Comprehensive Lower Leg Assessment, p. 5
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A. GENERAL CONSIDERATIONS FOR WOUND CARE:

- **Wound care Responsibilities:** All RNs/LPNs must assess, manage and document wounds for clients admitted with a wound or if a wound develops during an episode of care. This includes initiation and modification of wound treatments. Decisions are based on best practices, the needs of the client and changes in the wound. Ongoing consultation and information sharing re: wound status and treatment plan is maintained with the Regional Enterostomal Therapy Nurse (ETN), a Homecare Advisor or the HCCP Nurse Practice Consultant, including the client's physician.

When RNS and LPNs have successfully completed prescribed Wound Care training (using the Health Canada Modules), they **do not require** an order from a physician/nurse practitioner to provide wound care and management. Prior to completion of said training, RNs and LPNs will receive supervision from duly-trained RNs or LPNS.

- **Dressing Changes:** The standard for Wound Care is to provide daily dressings only if appropriate to meet the needs of the wound. The frequency of dressing change is based on the needs of the wound, such as: managing exudate, type and effectiveness of dressing material used, location and stability of the dressing, and client risk factors.
- **Inadequate Response to Wound Protocol:** If a wound does not respond to the Wound Protocol, the RN/LPN will discuss with the Regional ETN, a Homecare Advisor or the HCCP Nurse Practice Consultant, a SHS physician or nurse practitioner to determine which best practice interventions could best be applied to manage the client's wound(s) effectively and safely and/or whether to obtain orders for alternate care. This may include a referral to High Risk Wound Clinic by the RN/LPN.
- **Infected Wounds:** To determine whether a wound is infected or potentially infected, as the case may be, the RN/LPN uses his/her professional judgment, in consultation as needed, with the Regional ETN, a Homecare Advisor or the HCCP Nurse Practice Consultant, a SHS physician or nurse practitioner and/or advises the client to seek medical evaluation. Wound treatment is adjusted, as appropriate.
- **Prescribed Wound Care Treatments:** When the physician prescribes a wound care regime, the RN/LPN implements the wound care regime as prescribed. If the RN/LPN believes the prescribed treatment is **contraindicated**, wound care is begun and modified as needed. Note: Completing the One Health wound care modules allows RNs to change the prescribed treatment as needed without discussing the change with the Regional ETN.
- **Burns/Donor or Graft Sites:** A physician's order is required for all wounds classified as burns/donor or graft sites. Plastic surgery wounds must be managed according to the wound care regime prescribed by the plastic surgeon as should any modifications required.



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- **Wound Status Record:** Wound treatment plans are re-evaluated every 2 weeks and/or when there is a change in the wound or treatment and documented in the Wound Status Record within the CARE and/or WOLF EMR.

B. ACUTE WOUNDS: See the Homecare-Module 2, Wound Care – Topic 1: Acute Wounds at <http://www.abnurse-elc.com/campus/>

C. PRESSURE INJURIES: The Braden Risk Assessment Scale is used to identify individuals at risk for development of pressure ulcers. This validated and reliable measurement tool has been used for adult populations in hospitals, nursing homes and the community to link a score and level of individual risk to nursing interventions that promote, maintain and/or restore skin integrity. See Appendix VII: Braden Scale for Predicting Pressure Sore Risk. See also Section 8.7 of the Alberta Health Services (AHS) Wound Care Guidelines 2009 and Chapter 3 of ‘Best Practice Recommendations for the Prevention and Management of Pressure Injuries at <https://www.woundscanada.ca/health-care-professional/education-health-care-professional/advanced-education/12-healthcare-professional/110-supplements>.

Client Risk Factors to be considered include:

- Over 80 years of age
- Diastolic blood pressure less than 60 mmHg
- Cardiovascular disease
- Decreased dietary protein intake
- Chair/bed bound
- Impaired ability to reposition
- Increased temperature

- **Applicability:** The Braden Scale for Predicting Pressure Sore Risk tool can be completed by RN, LPN, or PT for all clients experiencing skin breakdown as well as those at risk for skin breakdown.
- **Frequency of Wound Assessment:** Clients should be assessed using the Braden Scale on admission and as conditions change.
- **Guidelines in filling out the Braden Scale:**
 - Follow** instructions as described on the front page of the document.
 - Assign** a numerical value reflecting the client’s status as described for each of the six risk factors then enter the total at the bottom of the column in the space provided.
 - For clients found to be at any risk** or those with an existing wound, request a consult to the appropriate discipline(s).
 - Treatment Protocol:** Clients with scores < 12 are considered ‘high risk’ and should be started on interventions to decrease their risk. See Appendix VIII: Braden Score Intervention.



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- e. **Prevention Protocol** - Clients with scores 13-18 are considered 'low to moderate risk' and should be started on interventions to maintain (and if possible, improve) their current status. See Appendix VIII: Braden Score Intervention
 - f. **Scan** completed form into the client's Electronic Medical Record (EMR).
- D. COMPREHENSIVE LOWER LEG ASSESSMENT:** See the Homecare 'Comprehensive Lower Leg Assessment Module' Topic 1 and Topic 2 at <http://www.abnurse-elc.com/campus/>.
- E. COMPRESSION THERAPY:** See the Home Care 'Comprehensive Lower Leg Assessment'- Topic 3 : 'Compression Therapy Module' at <http://www.abnurse-elc.com/campus/>.
- F. CONTINENCE MANAGEMENT:** See the Home Care 'Continence Management ' : Topic 1 and Topic 2: Continence Management at <http://www.abnurse-elc.com/campus/>.
- G. DEBRIDEMENT:** See the Homecare 'Wound Bed Preparation Module at <http://www.abnurse-elc.com/campus/> See also Section 7.0 in Regional Wound Care Guidelines: 'IMPORTANT'.
- H. DIABETIC FOOT SCREEN AND FOOT CARE:**
- a) **Diabetic/High Risk Foot Screen:** The diabetic/high risk foot screen incorporates an assessment of skin, skeletal, neurological, vascular status and protective sensation. Protective Sensation is assessed using the Semmes-Weinstein Monofilament as outlined in *Appendix V: Foot Care Assessment*. Refer also to the following sites.
 - i. 'Home Care-Module 2, Wound Care - Topic 3: Leg Ulcers' at <http://www.abnurse-elc.com/campus/>
 - ii. Alberta Health Services (AHS): Diabetes Foot Care Clinical Pathway Toolkit at <https://www.albertahealthservices.ca/scns/Page13331.aspx>
 - iii. The Primary Health Care Learning Portal eLearning Module Saving Limbs and Lives at <https://phc.myabsorb.ca> for the sections below (NB: See 'How to access the Primary Health Care Learning Modules, in Appendix X, page 36)
 - 1. A Guide to the Diabetic Foot Care Clinical Pathway, Part 1 – Overview
 - 2. A Guide to the Diabetic Foot Care Clinical Pathway, Part 2 – The Pathway
 - 3. A Guide to the Diabetic Foot Care Clinical Pathway, Part 3 – Case Study



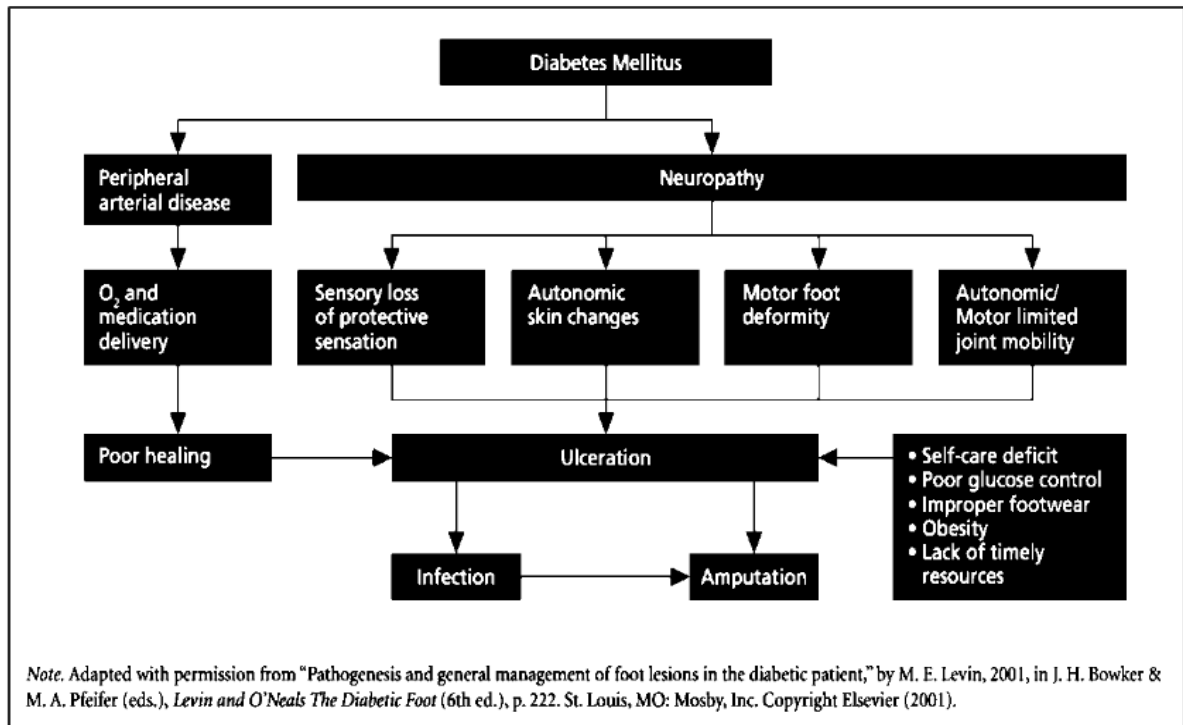
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- b) **Foot Assessment:** Foot examinations by health care providers should be an integral component of diabetes management to identify persons at risk for ulceration and lower extremity amputation. Foot complications are a major cause of morbidity and mortality. Those with peripheral neuropathy and Peripheral Arterial and Vascular Disease are predisposed to foot ulceration and infection, which may ultimately lead to lower-extremity amputation. Management of the diabetic foot requires a thorough knowledge of the major risk factors of amputation, frequent routine evaluation, meticulous preventive maintenance, patient education, early detection and treatment of diabetic foot ulcers. See Figure 1 'The Pathway to Diabetic Foot Ulcers' on the following page



- i. **High Risk for Amputation:** Characteristics that have been demonstrated to confer high risk of amputation in diabetic clients or those at high risk include:
- Previous ulceration or amputation
 - Increased age
 - Peripheral vascular disease (PVD)
 - Peripheral neuropathy
 - Limited joint mobility
 - Loss of protective sensation
 - Structural deformity
 - Renal transplantation
 - Poor socioeconomic status
 - Smoking



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- ii. When to Assess: Perform a complete inspection and examination of the diabetic feet using the AHS Diabetes Foot Screening Tool (Appendix VI: Diabetes Foot Screening Tool)
 - At the first visit **and at every** subsequent visit.
 - Annually in all clients with diabetes identified as being at low risk
 - More frequently for diabetes clients identified as being at moderate risk (4-6 months) and high risk (1-4 weeks)
- iii. What to Assess For: Be sure to assess five critical factors to screen for foot ulcer risk:
 - History of foot ulcer
 - Sensation
 - Structural and biomechanical abnormalities
 - Circulation
 - Client understanding of self-care

c) Foot Care in Diabetes: Establish an appropriate routine for regular foot care.

- i. Mandatory Training Prior to Providing Services: SHS requires that nursing staff complete an accepted, clinical foot care training (ex. Edmonton Foot Care Academy Education and Training for Nurses) prior to providing services to clients with diabetes or are high risk. Procedures for beginner and advanced level foot care are outlined the Edmonton Foot Care Academy – Advanced Foot Care Management Education and Resource Manual and relate to all settings where foot care may occur: clinics, health facilities, client homes or seniors’ lodges). Nurses who receive training in foot care will receive the manual for their use and reference. This applies to registered nurses and licensed practical nurses providing foot care services to FNIHB clients and who possess advanced knowledge and training about foot care.
- ii. IPAC: Nursing staff providing foot care must also comply with protocols and procedures for effective infection prevention and control (See SHS IPAC Policy and Procedure Manual) with the reprocessing reusable and single use medical equipment as necessary (See the SHS IPAC Policy and Procedure Manual: Reprocessing Medical Devices and Single Use Medical Devices).
- iii. Delegation of Basic Foot Care: Registered Nurses (RN) and Licensed Practical Nurses (LPN) may delegate basic foot care to non-regulated health care staff, Health Care Aides etc.) in certain situations. ***Appropriate delegation must consider the knowledge and training of the delegated staff member as well as the nurses’ role in the decision-making standards and the supervision of the health care aides.*** Non-invasive procedures are standard practice and can be done by trained health care staff. Clients requiring an invasive procedure or technique are to be referred to the nurse practitioner, medical doctor, or podiatrist.



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- iv. **Preventing Foot Complications:** Follow recommendation in RNAO BPG, Preventing Foot Complication in People with Diabetes. Available at http://rnao.ca/sites/rnao-ca/files/Foot_Comp_Diabetes_Updated.pdf. Also follow Best Practice Recommendations for the Prevention and Management of Diabetic Foot Ulcers at <https://www.woundscanada.ca/health-care-professional/education-health-care-professional/advanced-education/12-healthcare-professional/110-supplements>.
- v. **Foot Soaks:** Foot soaks are ***no longer practiced***. A foot cleansing with 70% alcohol prior to foot care is the acceptable method. Clients should be encouraged to wash and dry their feet daily instead of soaking them. If the integrity of the client's skin is accidentally breached during foot care, the area should be wiped with a skin antiseptic and covered loosely with a sterile gauze or Band-Aid®. The wound will require monitoring and documenting in the client's EMR. An incident report (SHS Incident Reporting and Analysis Form) will need to be completed and submitted.
- vi. **Client Education:** Pay special attention to client education and provide written material as necessary. Client education should include:
 - Strategies to minimize risk factors
 - Injury prevention
 - Awareness of personal risk factors; home environment, shoes, type of diabetes and level of continuous glucose control.
 - Annual inspection of feet by a health care professional.
 - Daily self-inspection of feet
 - Proper nail and skin care.
 - When to seek help or specialized referral.

I. DIGITAL PHOTOGRAPHY: See the Homecare: 'Digital Photography Module -Topic 1 and Topic 2' at <http://www.abnurse-elc.com/campus/>.

J. INTERMITTENT CATHETERIZATION: See the Home Care: 'Continence Management' – Topic 5: Intermittent Catheterization' at. <http://www.abnurse-elc.com/campus/>

K. LEG ULCERS (OR LOWER LEG WOUNDS): See the Home Care : Module 2, Wound Care : Topic 2: Leg Ulcers' <http://www.abnurse-elc.com/campus/> See also Section 8.2 (Arterial Ulcers) and Section 8.10 (Venous Leg Ulcers) of AHS Wound Care Guidelines 2009.



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L. LEVINE TECHNIQUE (TAKING A WOUND SWAB FOR BACTERIAL CULTURE)

- a) **Obtain** prescriber's order for swabbing a wound. Indicate on microbiology requisition whether the swab was taken from a superficial wound (<1.0 cm) or from a deep wound (>1.0 cm depth), the location of the wound as well as whether or not the client is currently receiving antibiotic therapy.
- b) **Take** a wound swab from an area of viable tissue where the clinical signs of infection are present. NB Before taking the wound swab, get rid of excessive debris and dressing product residue without unduly disturbing the wound surface by using a gentle stream of normal saline. Organisms found on the surface of the wound are often different to those that are the cause of the wound infection. Often there are skin cells and other harmless contaminants located on the wound surface.
 - i. Use sterile cotton tipped swab and culture medium in a pre-packaged collection and transport system (Amies transport media). **Check expiration date!**
 - ii. Don't swab pus, exudate, hard eschar or necrotic tissue. If there is no healthy granulation tissue present, there is no point in swabbing the wound as the results will only tell you what is on the surface, not what is actually in the live (viable) tissue.
 - iii. Rotate the swab tip in a 1.0 cm square area of clean granulation tissue for a period of 5 seconds, using gentle pressure to release tissue exudate. This may cause discomfort so prepare the client/patient of the possibility.
 - iv. Remove protective cap from culture medium and insert cotton tipped applicator into the culture medium without contaminating the applicator shaft.
 - v. Follow SHS protocol for getting specimen to the lab via courier. Store specimen at room temperature or 4 degrees Celsius. **DO NOT REFRIGERATE!**
 - vi. **NB: For Home Care nurses**, **DO NOT** allow transport medium to freeze or become overheated in your car before using it.

M. NEGATIVE PRESSURE WOUND THERAPY: See the Home Care – Negative Wound Pressure Therapy and the PICO System Module at <http://www.abnurse-elc.com/campus/>

N. NURSE AUTHORIZER NUMBER: The Nurse Authorizer Number is required for SHS Registered Nursing Personnel to be able to order Home Care client specific dressing supplies and equipment for approval through NIHB/Alberta (AB) Region Home and Community Care Program and acquisition through the SHS's preferred vendor of choice (ex. Market Drugs Medical). **NB:** Only Registered Nurses (RNs) can apply for a nurse authorizer number.



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- a) **Before a Nurse Authorizer Number is issued**, the SHS RN must successfully complete all the necessary educational requirements as outlined by FNIHB and NIHB (eLearning modules on the One Health website).
- b) **Upon completion of the mandatory wound care modules**, the SHS RN is responsible for completing and submitting, to the Alberta Regional Home and Community Care (HCC) Program the Alberta NIHB/ Home Care Medical Supplies and Equipment (M.S.& E) Program Application for Nurse Authorizer Number (Appendix IV).
- c) **The nurse authorizer number is issued only to SHS RNs** with valid practice permits with CARNA and in good standing with the College and at the discretion of the Alberta Regional Home and Community Care Program.
- d) **Prior to obtaining a Nurse Authorizer number** the SHS RN must fax the client specific order form in its entirety to the Alberta Regional Home Care office for approval by the Nurse Authorizer Process Administrator in order to obtain dressing supplies for Home Care clients.

O. MALIGNANT WOUND MANAGEMENT: See the Home Care: Module 2, Wound Care - Topic 3: Malignant Wounds' at <http://www.abnurse-elc.com/campus/> See also Section 8.6 of AHS Wound Care Guidelines

P. OSTOMY MANAGEMENT See the Home Care – Ostomy Management – Topic 1 and Topic 2: Ostomy Management at <http://www.abnurse-elc.com/campus/>

Q. PEDIATRIC WOUNDS See the Home Care : Module 3 -Wound Care, Special Groups , Topic 1 and Topic 2: Pediatric Wound Care at <http://www.abnurse-elc.com/campus/>

R. PERFORMING A DRESSING CHANGE: See also the Home Care : 'Wound Bed Prep' at <http://www.abnurse-elc.com/campus/>

- a) Sterile Dressings:
 - i. Sterile materials / supplies must be individually packaged and opened at the time of the dressing change.
 - ii. A sterile field must be used for sterile dressing procedures. A sterile tray or the opened packages may be used to create the sterile field.
 - iii. Sterile instruments must be used to manipulate or cut the sterile dressing material. NB: Only packaged, sterile instruments are used in Stoney Health Services Home Care Program and Clinic Services. After use, the instruments are immediately returned to the Clinic for cleaning and sterilization (See IPAC Policy and Procedure for Reprocessing Medical Devices)



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b) Clean Dressings:

- i. Clean dressing materials may be purchased in bulk and do not need to be individually wrapped. **NB:** Once opened, the dressing material stored in a container is **considered clean** and usable as long as the **packaging is closed when not in use.**
- ii. If wound dressing packaging does not match the client's needs (e.g. sterile packing comes five items to a package and the client needs two for a dressing change), the leftover contents of the package may be kept in the original packaging and sealed with a paper tape or plastic tape and placed in a new zip-lock bag. However, **the leftover material is considered clean, not sterile**, and may be used only for a clean dressing procedure.
- iii. Packaged, sterile instruments are used to cut clean dressing materials when using clean technique for dressing.

c) Wound Cleansing:

- i. Normal Saline solution is used to clean wounds, unless prescribers' orders state otherwise.
- ii. Solutions must be labeled with the date and time, when opened.
- iii. Once opened, a bottle of sterile normal saline is **sterile for immediate use** and can then be used for **clean procedures for up to 24 hours**. It must be kept at room temperature and closed between use.
- iv. Cleansing solutions in a bottle with an anti-reflux valve will remain sterile for entire usage time **only if** the bottle is kept capped between use.

- d) Wound Drainage: Depending on the product used for the wound, copious drainage may require a daily dressing change; moderate drainage, every other day and a small amount of drainage, every 4-5 days. Some dressing products can stay on up to 7 days.

S. SELECTION AND PROCUREMENT OF DRESSING PRODUCTS:

a) Selection:

- i. See Home Care: 'Selection of Appropriate Dressing Products – Topic 1 'at <http://www.abnurse-elc.com/campus/>
- ii. Wound dressings are products that support wound healing of a recoverable healable wound or optimize the management of a palliative maintenance wound. An ideal dressing meets the needs of both the wound and the client as well as addressing the characteristics of the wound and the client's risk factors. As such, it absorbs or donates moisture, provides insulation, protects tissue from secondary infection,



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controls odour, is free from toxic components, and is removable without trauma and with minimal discomfort to the client. NB: Not all maintenance wounds are palliative in nature.

b) Procurement:

- i. See the NIHB Client Specific Order Form 2018 Module and the 2018 videoconference on NIHB Client Specific Order Form 2018 at <http://www.abnurse-elc.com/campus/> and the FNIHB Client Specific Order Form in Appendix III.
- ii. All SHS Nursing Personnel must attend mandatory wound management education sessions. SHS RNs (only) must apply for a Nurse Authorizer number (See Procedure N.: Nurse Authorizer Number). The RN is accountable for what is ordered under his/her number.
- iii. RNs with or without an authorization number can order supplies using the Client Specific Order Form. If the RN has no authorization number, the order is sent for review and approval by the ETN, Home Care Advisor or Nurse Practice Consultant at the Alberta Regional Home and Community Care Program Office in Edmonton.
- iv. Determine what dressing supplies will be needed for a month in advance for all clients.
- v. Order wound care products on the NIHB/Ab Region Home Care Client Specific Medical Supplies and Equipment Order Form **NB:** Some products require Regional Approval and Prior Approval. **NB:** There are quantity limits on Advanced Wound Care Products.
- vi. Use the dressings from the home nursing stock supply for initial treatment and replace them later from ordered supplies
- vii. Obtain urgently needed supplies by obtaining a prescription from the physician and/or Nurse Practitioner for processing through a medical supplies preferred vendor of choice (ex. Morley Pharmacy) if they are not available through the Market Drugs Medical supplier and/or not on hand. **NB:** The pharmacy accepts prescription from NPs as well.

T. WOUND ASSESSMENT AND DOCUMENTATION:

- a) Assessment: See the Home Care – Module 1 Wound Assessment- Topic 1: Wound Assessment at <http://www.abnurse-elc.com/campus/>.
- b) Documentation: The terminology and assessment tools used to describe a wound must be standardized. All health care providers who are doing wound care must document and describe a wound in exactly the manner it is observed in the Wound Status Record shown in Appendix II



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- i. Accurate and complete wound measurements are required to evaluate a wound status, create a treatment plan, and document the results. Careful documentation of even small changes in wound status will show an improvement or deterioration.
- ii. When assessment and measurement fail to show progress in healing, re-evaluation of the treatment plan and goals is essential.

U. WOUND BED PREPARATION: See the Home Care: Wound Bed Preparation – Topic 1 and Topic 2: Wound Bed Preparation: at <http://www.abnurse-elc.com/campus/>

V. WOUND CARE EDUCATION: Additional education is necessary for the Home Care professional to gain the knowledge and skills required to support a comprehensive process of wound management that involves assessment, intervention, outcomes and documentation. Wound management education is therefore mandatory for new RN/LPNs hired by SHS. Enterostomal Therapists with Health Canada have developed several online learning modules which are followed by live, online case studies with an ET at Health Canada. The online learning modules are available at: <http://www.abnurse-elc.com/campus/> or via the OneHealth Portal and include topics in the following:

- Acute Wounds
- Assessment of Wounds
- Comprehensive Lower Leg Assessment
- Compression Therapy
- Continence Management
- Digital Photography
- Intermittent Catheterization
- Leg Ulcers (or Lower Leg Wounds)
- Negative pressure wound therapy
- Malignant Wounds
- Ostomy Management
- Pediatric Wounds
- Procurement of Dressing Products
- Selection of Appropriate Dressing Products
- Wound Assessment and Documentation
- Wound Bed Prep

In addition, staff can view the Annual update of the NIHB Client Specific Order Form (NIHB product formulary) via the Module 'NIHB Client Specific Ordering Annual Update'. This presentation is provided live on Blackboard Collaborate (live interactive learning) once every fiscal year and staff are strongly encouraged to attend the live session.

Should staff not be able to attend the live session or have joined SHS after the most recent update, the session is recorded and is available for viewing on the e-learning website. Live case studies for all modules must be completed by all new SHS Nursing Personnel within a 6-month time frame according to the schedule set by Health Canada.



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5. INDICATORS AND FORMULAE:

Indicators /Measures	Calculation
1. Wound Infections	Total wounds found infected (per type of infection) within 30 days of D/C from Hospital x 100 % /Total wounds in clients being D/C from hospital
	Total wounds found infected (per type of infection) after 30 days of D/C from Hospital x 100 % /Total wounds in clients being D/C from hospital

6. REFERENCES:

- Alberta Health Services (AHS) Calgary Zone Integrated Home Care Wound Care Interim Policy
- Alberta First Nations Home Care Program Policies Manual
- Alberta First Nations Home Care Program Procedure Manual
- Alberta Health Services Wound Care Guidelines, 2013
- Calgary Lab Services website. Available at:
- Edmonton Foot Care Academy <http://www.edmontonfootcare.ca/efc-academy>
- Evidence-based Wound Care: Home Care Perspective. The Canadian Home Care Association 2012. Available at: <http://www.cdnhomecare.ca/media.php?mid=3297>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Homecare-Module 2, Wound Care – Topic 1: Acute Wounds at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Homecare- Comprehensive Lower Leg Assessment – Topic 1: Lower Leg Assessment Module at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care- Comprehensive Lower Leg Assessment – Topic 2: Compression Therapy Module) at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care-Continenence Management – Topic 1: Continenence Management at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Homecare- Wound Bed Preparation Module at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care-Module 2, Wound Care – Topic 3: Leg Ulcers at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Homecare- Digital Photography Module at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care – Continenence Management – Topic 5: Intermittent Catheterization at <http://www.abnurse-elc.com/campus/>



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- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care – Module 2, Wound Care – Topic 3: Leg Ulcers at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care – Module 2, Wound Care – Topic 4: Malignant Wounds at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care – Ostomy Management – Topic 1: Ostomy Management at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care – Module 3, Wound Care, Special Groups – Topic 1: Pediatric Wound Care at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care – Wound Bed Prep at <http://www.abnurse-elc.com/campus/>
- First Nations Inuit Health Branch (FNIHB) Nursing eLearning Portal. Home Care – Module 1 Wound Assessment at <http://www.abnurse-elc.com/campus/>
- <http://www.calgarylabservices.com/lab-services-guide/microbiology/Source/>
- Newfoundland and Labrador Skin and Wound Care Manual – July 2008. Available at: <http://westernhealth.nl.ca/uploads/PDFs/wound%20care%20manual%20for%20dianne%20clements%20final.pdf>
- One Health Home and Community Care Forms. Braden Scale for Predicting Pressure Sore Risk.
- One Health Home and Community Care Forms. Braden Score Intervention.
- One Health Home and Community Care Forms. Foot Care Assessment.
- One Health Home and Community Care Forms. Program Diabetic High Risk Foot Screen.
- Registered Nurses' Association of Ontario (2007). Reducing Foot Complications for People with Diabetes. Available at http://rnao.ca/sites/rnao-ca/files/Foot_Comp_Diabetes_Updated.pdf
- Registered Nurses' Association of Ontario (2013). Assessment and Management of Foot Ulcers for People with Diabetes. Available at http://rnao.ca/sites/rnao-ca/files/Assessment_and_Management_of_Foot_Ulcers_for_People_with_Diabetes_Second_Edition1.pdf
- South West Regional Wound Care Toolkit: Levine Method for Wound Swab Culture & Sensitivity. Dec 14, 2011. Available at: http://www.southwesthealthline.ca/healthlibrary_docs/B.7.3.LevineWoundSwabMethod.pdf
- Wound Care Canada (2017) : Foundations of Best Practice for Skin and Wound Management. A supplement; <https://www.woundscanada.ca/health-care-professional/resources-health-care-pros/wcc-magazine>



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7. RESPONSIBILITIES: The Managers of Home Care and Primary are responsible for the application of this policy

8. DEVELOPED BY:

Anne Malimban, Home Care Manager

Name & Title

March 5, 2015

Date:

9. APPROVALS:

B. Khan
Executive Director

Date



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APPENDIX I: ALBERTA REGION HOME CARE PROGRAM WOUND CARE PRODUCT FORMULARY

Product Category	Indications for Use	Precautions/ Contraindications	Current Product
Prepared Wound Cleansers	Used for cleansing chronic wounds.		Skintegrity
Continuous Moist Saline Gauze	Stages II, III, and IV wounds to keep the wound moist and absorb excess exudate	Change tid to qid (must stay moist to keep wound bed moist)	Curity Saline Dressing
Impregnated Non-Adherent Dressings	<p>Stage II and III wounds, burns, grafts, suture lines to prevent tissue adherence.</p> <p>Impregnated gauze used as a primary dressing in the management of wounds that are infected or colonized.</p>	<p>Monitor condition of periwound skin to avoid exposure to excess moisture</p> <p>No contraindications documented to date. Not intended as a treatment for clinical infection. If signs of clinical infection are present, consult a physician for antibiotic therapy.</p>	<p>Restore Contact Layer Dressing</p> <p>Curity AMD Gauze packing strips 1/4 inch 1/2 inch Kendall AMD Gauze Sponges</p>
Hydrogels	Used to provide a moist wound environment. Can be used in combination with transparent films, foam, or other non-adherent dressing. Can be used with hydrocolloids as well.	<p>Contraindicated in third degree burns. Gel alone is not indicated for wounds with moderate to heavy exudate or to fill wound space (exception: wounds too small to pack other dressing product) Close monitoring of wounds for periwound maceration is required. A skin sealant or protectant may be required to protect periwound skin.</p>	Intrasite gel
Transparent Films	Stage I, II wounds with scant drainage. May be used on high-risk intact skin. May be used in combination with other dressing products as a cover dressing.	<p>This dressing has no capacity to absorb. Change every 5-7 days. Remove with caution to avoid skin stripping. Contraindicated in third degree burns.</p>	Opsite
Hydrocolloids	Stage I, II, and III wounds	<p>Contraindicated in infected wounds. Contraindicated in third degree burns. Not recommended on neuropathic ulcers - pastes and gels may be used. Change q 2-3 days and prn if leaking. Not to be left on longer than 7 days.</p>	<p>Duoderm Signal Duoderm Extra Thin</p>



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Product Category	Indications for Use	Precautions/ Contraindications	Current Product
Hydrogels	Used to provide a moist wound environment. Can be used in combination with transparent films, foam, or other non-adherent dressing. Can be used with hydrocolloids as well.	Contraindicated in third degree burns. Gel alone is not indicated for wounds with moderate to heavy exudate or to fill wound space (exception: wounds too small to pack other dressing product) Close monitoring of wounds for periwound maceration is required. A skin sealant or protectant may be required to protect periwound skin.	Intrasite gel
Transparent Films	Stage I, II wounds with scant drainage. May be used on high-risk intact skin. May be used in combination with other dressing products as a cover dressing.	This dressing has no capacity to absorb. Change every 5-7 days. Remove with caution to avoid skin stripping. Contraindicated in third degree burns.	Opsite
Hydrocolloids	Stage I, II, and III wounds	Contraindicated in infected wounds. Contraindicated in third degree burns. Not recommended on neuropathic ulcers - pastes and gels may be used. Change q 2-3 days and prn if leaking. Not to be left on longer than 7 days.	Duoderm Signal Duoderm Extra Thin
Charcoal Dressings	Used on malodorous wounds resulting from infection, bacterial contamination and malignant wounds.	Dressings may be overlapped to accommodate the size of the wound, but should never be cut. Used as a secondary dressing. Must be covered with another dressing and be sealed around the edges.	Actisorb Silver 220
Multi-Layer (combination) Dressings	Used for stage II, III, and IV wounds with moderate drainage. May be used alone or in combination with other dressing products.	Contraindicated in third degree burns. Not recommended for use in heavily draining wounds or as a primary dressing for full-thickness wounds.	Aldress Combiderm Versiva
Silver Impregnated Dressings	Used in partial and full thickness wounds. May be used over debrided and grafted wounds.	Contraindicated in patients with known sensitivity to silver. Acticoat - do not moisten with saline	<i>Aquacel Ag Extra*</i> <i>Aquacel Ag Strip*</i> <i>Aquacel Foam Adhesive*</i> <i>Acticoat Flex*</i> <i>Acticoat Flex Ribbon*</i> <i>Silvasorb*</i>



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Product Category	Indications for Use	Precautions/ Contraindications	Current Product
Non-Cytotoxic Antibacterial Agents	Used in the management of draining wounds that are infected or colonized.	Iodosorb (TM) is contraindicated in patients with sensitivity to iodine, pregnant, or breast-feeding patients, and those with a history of Hashimoto's thyroiditis, Grave's disease, or nontoxic nodular goiter. Use with caution in patients with history of thyroid disorder. Change dressing q 3 days.	<i>Iodosorb*</i> <i>Hydrofera Blue*</i> <i>Hydrofera Blue (Heavy Exudate)*</i> <i>Medihoney</i>
ORC Collagen Agents	Used in the management of non-healing wounds to stimulate healing.	Not intended for use on infected wounds, or wounds with eschar and slough. Contraindicated in wounds with active vasculitis, third-degree burns, or in patients with sensitivity to ORC, collagen, and silver (Prisma only).	<i>Promogran*</i> <i>Prisma*</i>

Negative Pressure Wound Therapy	Single use negative pressure wound therapy system that is used for up to 7 days. The system must be replaced after 7 days. System delivers 80 mmHg continuous negative pressure. Dressing manages fluid exudate associated with small to medium sized wounds. Up to 7 days wear time with dressing dependent on the amount of exudate. Dressing can be disconnected to allow showering. Dressing is waterproof.	Do not apply dressing port directly over the open wound. Sinus tracts, tunnels and depth in the wound may be packed with antimicrobial gauze.	<i>Smith + Nephew PICO System</i> <i>Small</i> <i>Medium</i> <i>Large *</i>
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* Product requires Regional Approval



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APPENDIX II: WOUND STATUS RECORD (HEALTH CANADA)

Health Canada / Santé Canada		<i>Your health and safety... our priority.</i> / <i>Votre santé et votre sécurité... notre priorité.</i>					
WOUND STATUS RECORD							
Client Name: _____							
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	Band:		_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _			
D.O.B.	/ -- / -- / -- /	PHN:		_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _			
	yyy / mm / dd						
Document the full assessment every 2 weeks and/or when there is a change in the wound or treatment.							
Date:	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
Underlying Cause:	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
Location:	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
Stage	I/II/III/IV	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Wounds cannot be staged if infected or necrotic tissue.	Contributing Factors	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Phase	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Size in cm.	Length	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Width	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Depth	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Drainage	Colour	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Odour	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Consistency	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Type	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Amount	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
Wound bed Tissue	Red	%	%	%	%	%	%
	Yellow	%	%	%	%	%	%
	Black	%	%	%	%	%	%
Periwound Skin	Describe	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Undermining (cm)	Cm.	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Location	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Sinus Tract	Cm.	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Location	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Pain	analog scale) - 10	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	analgesic req. (describe)	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Wound Care Plan/Treatment	Underlying cause: treatment	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Cleansing solution	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Skin moisturizer	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Sealants/barriers	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	1° Primary dressing	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	2° dressing (if required)	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
	Taping	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Frequency of change	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
Teaching Plan:	Reinforce at each visit.						
Nurses Initial:		_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _					
Other Comments:							
Initial and date when the dressing has been changed between full assessments.							
yyyy/mm/dd	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
yyyy/mm/dd	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
yyyy/mm/dd	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
yyyy/mm/dd	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
yyyy/mm/dd	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _						
Odour: (N = none; M = mild; F = foul); Texture: (T = thin; MU = mucous; ST = stringy); Type: (S = serous; SS = sero-sang; P = purulent); Amount: (nil; min; mod; excessive); Wound Bed: (BE = Black Eschar, YGS = Yellow/Grey Slough, HP/GT = Healthy pink/granulation tissue); Periwound Skin: (IN = Intact; IND = Induration; ED = Edema; E = Erythema; M = Maceration)							

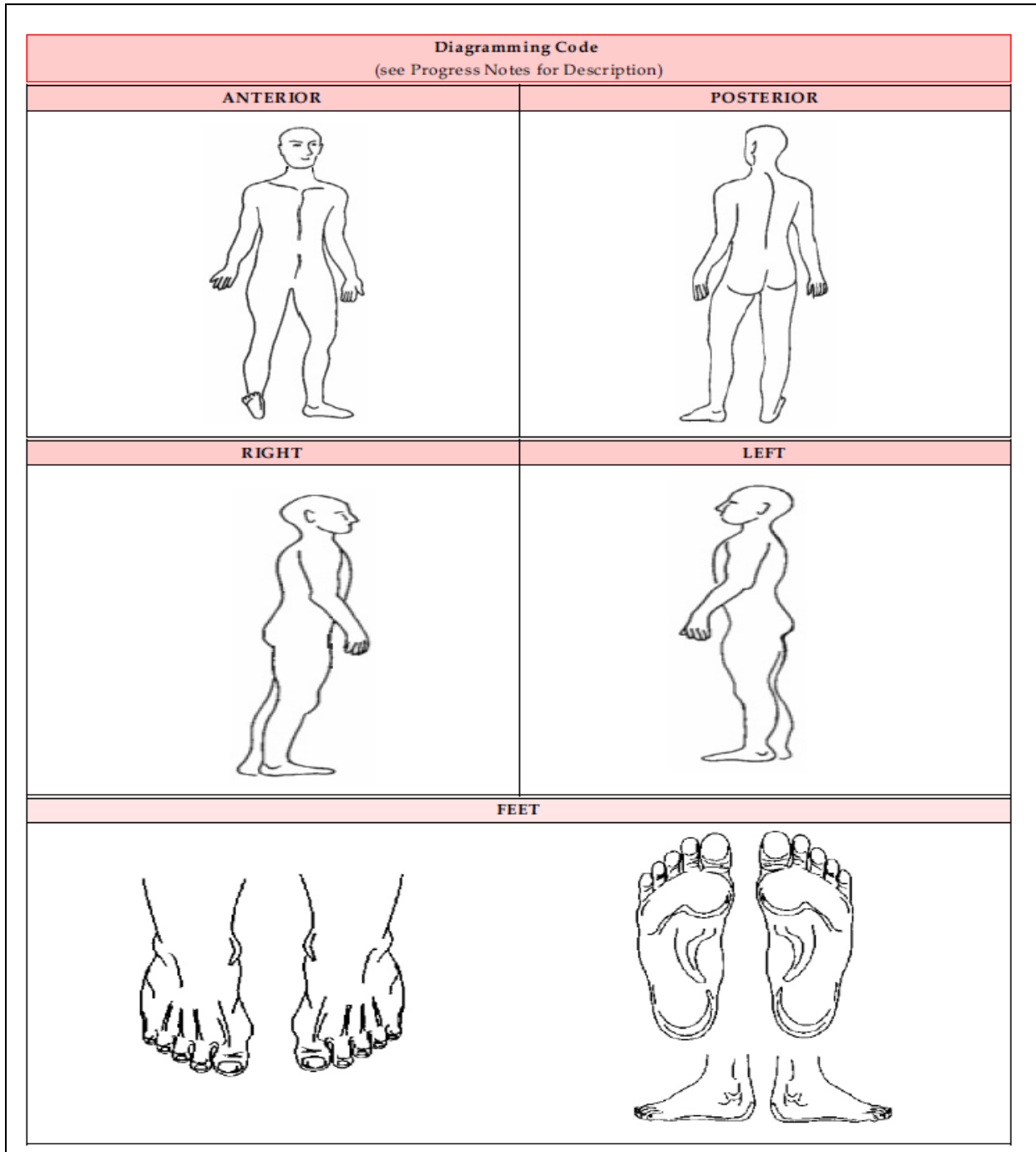


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APPENDIX III: FNIHB CLIENT SPECIFIC ORDER FORM

 		NIHB/AB REGION HOME CARE Client Specific Medical Supplies and Equipment Order Process	
Date: _____ HCCP Contact: <u>780-495-2687 FAX</u> <u>780-442-6798 Phone</u>		<small>NOTICE TO RECIPIENT OF HEALTH INFORMATION</small> <small>As required by Section 42 of the Health Information Act, the individually identifying diagnostic, treatment and care information being disclosed to you by our agency is being disclosed to you under the authority of the Health Information Act. The health information being provided to an individual who is responsible for providing continuing treatment and care to the individual who is the subject of the information as per Sec. 35(1)(b). This information can only be used for the purposes of providing health services (including obtaining payment for these services) for the individual who is the subject of this information.</small>	
Total # of Pages: _____ <small>(Only submit pages with items to order)</small>			
Client Information: (Complete all information clearly. Illegible or missing fields will cause unnecessary delays. Thank you!)			
Client's Surname:		Date of Birth: DD/MM/YY	
Given Names:		Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
Client DIAND #:		AB Health #:	
Medical Condition being treated (please provide detailed information for all clients for every order):		<input type="checkbox"/> Admitted Home Care Client <input type="checkbox"/> New Home Care Client <input type="checkbox"/> Renal Client <input type="checkbox"/> Diabetic Client	
This order represents _____ days supply.		<small>30 days maximum for wound care 90 day for incontinence supplies</small>	
Home and Community Care Nurse Information:			
Name (please print):		Community:	
Telephone:		Fax:	
Signature:			
Preferred Vendor:			
1 st Choice: Name of Vendor (please print):			
Telephone:		Fax:	
2 nd Choice: Name of Vendor (please print):			
Telephone:		Fax:	
Name of Authorizer: (if no authorizer, please leave blank)			
Name (please print):		Date:	
Signature:		Authorizer #:	
ONCE COMPLETE FORWARD TO: 780-495-2687			
065-AB-HC Revised Sept. 12, 2018		1	



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Client Specific Medical Supplies & Equipment Program Order Process

Client Initials: _____

GENERAL SUPPLIES						
Product Description	Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials	
Gloves Examination, PVC, non-sterile	Small 100/BOX	99400318	BX	1 box per 30 days		
	Medium 100/BX	99400318	BX			
	Large 100/BX	99400318	BX			
Needles	18 G, 1" 100/BX	09991401	BX	1 box per month		
	25 G, 5/8" 100/BX	09991385	BX	1 box per month		
Safety Syringe	3 mL Luer Lock each	99400530	EA	12 ea per 90 days		
Large Syringe	20 mL Luer Lock, each	99400548	EA	4 per month		
	30 mL Luer Lock, each	09991377	EA	4 per month		
Sharps Container 1.4L	60 mL Catheter Tip, each	99400320	EA	4 per month		
		99401026	EA	2 per 30 days		
EasiCleanse (for bedridden clients only)	5/pk	11111111	PK			
Topical Preparations						
Product Description	Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials	
Barrier	Dimethylpolysiloxane 20% 50g CR	02060841	TU			
Wipes	Skin Protective 50/BX (Allkare)	99400411	PA	BX	4 boxes per year	
	Alcohol, 200/BX	00795232		BX	(injection use only)	
	Adhesive remover wipes, 50/BX	99400476	PA	BX	6 boxes per year	
	Tolnaftate 1% powder 100g (Tinactin)	00576042		BT		
Tape						
Product Description	Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials	
Steri-Strips	6 mm (1/4") x 7.5 cm, 3/EN	99400446	PA	EN		
	12 mm (1/2") x 10 cm, 6/EN	99400446	PA	EN		
Tape	Hypafix 10 cm, 10 m/BX	99400444		BX		
	Micropore 2.5 cm, 9 m/EA	99400444		EA		
	Transpore 2.5 cm, 9 m/EA	99400444		EA		
WOUND CARE						
Specialized Dressings						
Product Description	Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials	
Disposable Wound Measurement Ruler	25/pd		EA	1 pad per month		
Calcium Alginate dressing	Kaltostat 7.5 x 12 cm, 10/BX	99400454	PA	BX	2 boxes per month	
	Kaltostat 2g strip 5/BX	99400454	PA	BX	2 boxes per month	
	Mesalt 10 x 10 cm, 30/BX	99400454	PA	BX	2 boxes per month	
	Mesalt ribbon, 10/PK	99400454	PA	PK	2 boxes per month	
Charcoal Dressing	Actisorb Silver 10.5 x 10.5 cm, 10/BX	99400455	PA	BX	2 boxes per month	
Foam Dressing	Mepilex foam, 10 x 20, 5/BX	99400456	PA	BX	4 boxes per month	
	Mepilex XT 10 x 10 cm, 5/BX	99400456	PA	BX	4 boxes per month	
	Mepilex XT 10 x 20 cm, 5/BX	99400456	PA	BX	4 boxes per month	
	Aquacel Foam Adhesive 10 x 10 cm, 10/BX	99400456	PA	BX	4 boxes per month	
	Biatain Silicone Adhesive 7.5 x 7.5 cm, 10/BX	99400456	PA	BX	2 boxes per month	



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Related Polices & Procedures: SHS IPAC Policy; SHS Skin Suture, Clip & Staple Removal Policy

Client Specific Medical Supplies & Equipment Program Order Process

Client Initials: _____

Biatain Silicone Adhesive 10 x 10 cm, 10/BX	99400456	PA	BX	2 boxes per month	
Biatain Silicon Adhesive 15 x 15 cm, 5/BX	99400456	PA	BX	4 boxes per month	
Biatain Foam Super-Adhesive 15 x 15 cm, 10/BX	99400456	PA	BX	2 boxes per month	
Biatain Form Super-Adhesive 20 x 20 cm, 10/BX	99400456	PA	BX	2 boxes per month	
Hydrocolloid dressing DuoDerm Signal 10 x 10 cm, 5/BX	99400461	PA	BX	4 boxes per month	
DuoDerm Signal 14 x 14 cm, 5/BX	99400461	PA	BX	4 boxes per month	
DuoDerm Extra Thin CGF 10 x 10 cm, 10/BX	99400461	PA	BX	2 boxes per month	
Hydrophilic Dressing Triad Wound Drsg 71 gm	99400461	PA	TU	2 tubes per month	
Hydrofiber Dressing Aquacel Extra 10 x 10 cm, 10/BX	99400454	PA	BX	2 boxes per month	
Aquacel 2 x 45 cm, 5/BX	99400454	PA	BX	4 boxes per month	
Exufiber Dressing 10 x 10 cm, 10/BX	99400454	PA	BX	2 boxes per month	
Exufiber Dressing 2 x 50 cm, 5/BX	99400454	PA	BX	2 boxes per month	
Hydrogel Intrasite gel, 10/BX	99400460	PA	BX	1 box per month	
Multi-layer Dressing Primapore 8 x 10 cm, 20/BX	99400811	PA	BX	2 boxes per month	
Primapore 35 x 10 cm, 20/BX	99400811	PA	BX	2 boxes per month	
Alldress 10 x 10 cm, 10/BX	99400811	PA	BX	2 boxes per month	
Alldress 15 x 20 cm, 10/BX	99400811	PA	BX	2 boxes per month	
Non-Adherent Dressing Impregnated					
Mepitel One 5 x 7.5 cm, 10/BX	99400463	PA	BX	2 boxes per month	
Mepitel One 7.5 x 10 cm, 10/BX	99400463	PA	BX	2 boxes per month	
Restore Contact Layer 10 cm x 12 cm, 10/BX	99400463	PA	BX	2 boxes per month	
Antimicrobial (AMD) Dressing					
AMD Super Sponges 10 cm x 17 cm, 20 x 2" s/BX	99400462	PA	BX		
AMD Packing Strips 0.6 cm (1/4") x 91 cm	99400468		EA		
AMD Packing Strips 1.2 cm (1/2") x 91 cm	99400468		EA		
AMD Gauze 11.4 cm x 3.5 m/ROLL	99400468		EA		
Transparent film dressing OpSite 10 x 12 cm, 50/BX	99400464	PA	BX	1 box per month	
OpSite Post-Op dressing 9.5 x 8.5 cm, 20/BX	99400464	PA	BX	1 box per month	

Dressings

Product Description	Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials
Bandage, gauze, elastic ("Kling")					
5 cm, 12/BG	99400448		BG		
7.5 cm, 12/BG	99400448		BG		
10 cm, 12/BG	99400448		BG		
15 cm, 6/BG	99400448		BG		
Bandage, tubular elastic latex free ("BurnNet")					
Size 1, 25 m/BX (Ex. Fingers, Toes)	99400451		BX		
Size 2, 25 m/BX (EX. Fingers, Wrist)	99400451		BX		
Size 3, 25 m/BX (Ex. Knee, Foot, Elbow, Hand)	99400451		BX		
Size 4, 25 m/BX (ex. Knee, Foot, Elbow, Hand)	99400451		BX		
Size 5, 25 m/BX (Ex. Calf, Thigh)	99400451		BX		
Size 7, 25 m/BX (Ex. Chest, Abdomen, Axilla)	99400451		BX		
Gauze, non-sterile, 4 ply	10 x 10 cm, 200/PG	99400458	PG		
Gauze, sterile, 4 ply	5 x 5 cm, 25 pkg of 2/TR	99400459	TR		
	7.5 x 7.5 cm, 25 pkg of 2/TR	99400759	TR		
	10 x 10 cm, 25 pkg of 2/TR	99400760	TR		
Gauze packing strip, sterile	0.6 cm x 4.5 m (Nu-gauze)	99400468	EA		



STONEY HEALTH SERVICES POLICY AND PROCEDURES

SKIN & WOUND CARE MANAGEMENT

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Gauze packing strip, sterile	1.3 cm x 4.5 m (Nu-gauze)	99400468		EA		
Pad, abdominal, sterile	12 x 22 cm, 36/PG	99400457		PG		
Pad, eye, sterile	50/BX	99400466		BX		
Miscellaneous						
Product Description		Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials
Dressing tray, sterile disposable	BASIC	99400764	PA	EA	1 per dressing change	
	MINOR	99400764	PA	EA	1 per dressing change	
Sodium Chloride 0.9% (NS) irrigation	100 mL squeeze	99400469		BT		
	500 mL screw cap bottle	99400469		BT		
Liner, Classic Ultra	17 x 40 cm 20/package	99400457		EA		
Liner, Classic Super	10 x 28 cm 50/package	99400457		EA		
Betadine Solution	500 mL			EA		
Medi-Honey Gel	50 gm tube	99400901	PA	EA	1 tube per month	
CONTINENCE SUPPLIES						
Product Description		Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials
Bedpan	Fracture, non-autoclavable plastic	99400294		EA	1 per 3 years	
Catheter, Foley 5 mL, indwelling latex	12 FR	99400420	PA	EA	4 ea per 3 months	
	14 FR	99400420	PA	EA	4 ea per 3 months	
	16 FR	99400420	PA	EA	4 ea per 3 months	
	18 FR	99400420	PA	EA	4 ea per 3 months	
	22 FR	99400420	PA	EA	4 ea per 3 months	
Catheter	Self-cath Female 6 inches 14 FR	99400421		EA	360 ea per 3 months	
	Self-cath Male 16 inches 14 FR	99400421		EA	360 ea per 3 months	
Catherization Tray		99400425	PA	EA		
Lubricant	(Muko) 3.5 g pouch, 100/BX	99400919		BX		
Urine bag	Leg bag with tubing, medium 562 mL	99400431	PA	EA	52 per year	
	Leg bad with tubing, large 946 mL	99400431	PA	EA	52 per year	
	Bedside bag, 2L	99400428	PA	EA	52 per year	
Urinary irrigation set		99400426	PA	EA		
Urinal	Male spill-proof, autoclavable	99400306		EA	1 per 3 years	
Underpads (Heavy Use), disposable INCONTINENCE CLIENTS ONLY						
	Blue 43 x 60 cm (17 x 24") 300/BX	99400442	PA	BX	1 box per 6 months	
Underpads (Light Use), disposable						
	Blue 43 x 60 cm (17 x 24") 25/BG	11111111	PA	BG	2 pks per month	
Underpads, reusable	24 x 36"/EA	99400443	PA	EA	1 per month	
Adult Mesh Pants	Mesh pants, Small-Medium 5/BG	99400755	PA	BG	2 bags per month	
	Mesh pants, Large-Extra Large 5/BG	99400755	PA	BG	2 bags per month	
	Mesh pants, XX-Large, 5/BG	99400755	PA	BG	2 bags per month	
Pads for Mesh Pants						
Attends Bladder Control Pads	Ultimate, 20/BG	99400438	PA	BG	150 per month	
	Day Regular, 24/BG	99400438	PA	BG	150 per month	
	Day Plus, 24/BG	99400438	PA	BG	150 per month	
	Super, 18/BG	99400438	PA	BG	150 per month	
	Overnight, 18/BG	99400438	PA	BG	150 per month	



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Client Specific Medical Supplies & Equipment Program Order Process

Client Initials: _____

Diapers, Attends						
Briefs, Extra absorbent; Medium, (32-44") 24/BG	99401090	PA	BG	150 per month		
Briefs, Extra absorbent; Regular, (44-56") 24/BG	99401090	PA	BG	150 per month		
Briefs, Extra absorbent; Large, (44-58") 24/BG	99401091	PA	BG	150 per month		
Briefs, Extra absorbent; X-Large, (58-63") 24/BG	99401091	PA	BG	150 per month		
Briefs, Extra absorbent; XX-Large, (58-68") 24/BG	99401091	PA	BG	150 per month		
Pull Up Attends						
Protective Underwear – Super Plus Absorbency; Youth/Small, (22 – 24", 80-120 lbs), 20/BG	99401087	PA	BG	150 per month		
Protective Underwear – Super Plus Absorbency; Medium (34 - ", 120-175 lbs), 20/BG	99401087	PA	BG	150 per month		
Protective Underwear – Super Plus Absorbency; Large, (44 – 58", 175-210 lbs), 18/BG	99401088	PA	BG	150 per month		
Protective Underwear – Super Plus Absorbency; X-Large (58 – 68", 210-250 lbs) 14/BG	99401088	PA	BG	150 per month		
Protective Underwear – Super Plus Absorbency; XXXL (68 – 80", 250 lbs.+) 12/BG	99401089	PA	BG	150 per month		
Ostomy Supplies						
Product Description	Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials	
Paste Adapt Paste 1 x 2 oz.	99400408	PA	TU	1 per month		
Powder Adapt Stoma Powder 1 x 1 oz.	99400398	PA	TU	1 per month		
Flanges						
Flat Cut-to-fit 44mm Hollister #14202 5/BX	99400742	PA	BX	50 per 3 months		
57mm Hollister #14203 5/BX	99400742	PA	BX	50 per 3 months		
Convex Cut-to-Fit 44mm Hollister #14402 5/BX	99400743	PA	BX	50 per 3 months		
57mm Hollister #14403 5/BX	99400743	PA	BX	50 per 3 months		
Pouches						
Drainable Ileostomy/Colostomy 44mm Hollister #18172 10/BX	99400415	PA	BX	30 per 3 months		
57mm Hollister #18173 10/BX	99400415	PA	BX	30 per 3 months		
Drainable Urostomy 44mm Hollister #18922 10/BX	99400745	PA	BX	30 per 3 months		
57mm Hollister #18923 10/BX	99400745	PA	BX	30 per 3 months		
DIABETIC SUPPLIES						
Product Description	Benefit Code	Status	Quantity Ordered	NIHB/Regional Allowable Quantities	Authorizer Initials	
Bayer Next EZ Test Strips, 100/BX	97799877		BX			
Bayer Microlet lancets, 200/BX	00977492		BX			
One Touch Ultra supplies (meter not available)						
One Touch Ultra Test Strips 100/BX	44123025		BX			
One Touch Ultra Soft Lancets 100/BX	00901359		BX			
One Touch Delica Lancets 100/BX	00901359		BX			

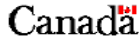


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NIHB/AB REGION HOME CARE Client Specific Medical Supplies and Equipment Order Process

Date: _____
HCCP Contact: 780-495-2687 FAX
780-442-6798 Phone

NOTICE TO RECIPIENT OF HEALTH INFORMATION
 As required by Section 42 of the *Health Information Act*, the individually identifying diagnostic, treatment and care information being disclosed to you by our agency is being disclosed to you under the authority of the *Health Information Act*. The health information being provided to an individual who is responsible for providing continuing treatment and care to the individual who is the subject of the information as per Sec. 35(1)(b). This information can only be used for the purposes of providing health services (including obtaining payment for these services) for the individual who is the subject of this information.

Total # of Pages: _____
 (Only submit pages with items to order)

Client Information: (Complete all information clearly. Illegible or missing fields will cause unnecessary delays. Thank you!)

Client's Surname:	Date of Birth: DD/MM/YY
Given Names:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Client DIAND #:	AB Health #:
Medical Condition being treated (please provide detailed information for all clients for every order):	
<input type="checkbox"/> Admitted Home Care Client <input type="checkbox"/> New Home Care Client <input type="checkbox"/> Renal Client <input type="checkbox"/> Diabetic Client	
This order represents _____ days supply. <small>30 days maximum for wound care 90 day for incontinence supplies</small>	

Home and Community Care Nurse Information:

Name (please print):	Community:
Telephone:	Fax:
Signature:	

Preferred Vendor:

1st Choice: Name of Vendor (please print):	
Telephone:	Fax:
2nd Choice: Name of Vendor (please print):	
Telephone:	Fax:

Name of Authorizer: (if no authorizer, please leave blank)

Name (please print):	Date:
Signature:	Authorizer #:

ONCE COMPLETE FORWARD TO: 780-495-2687



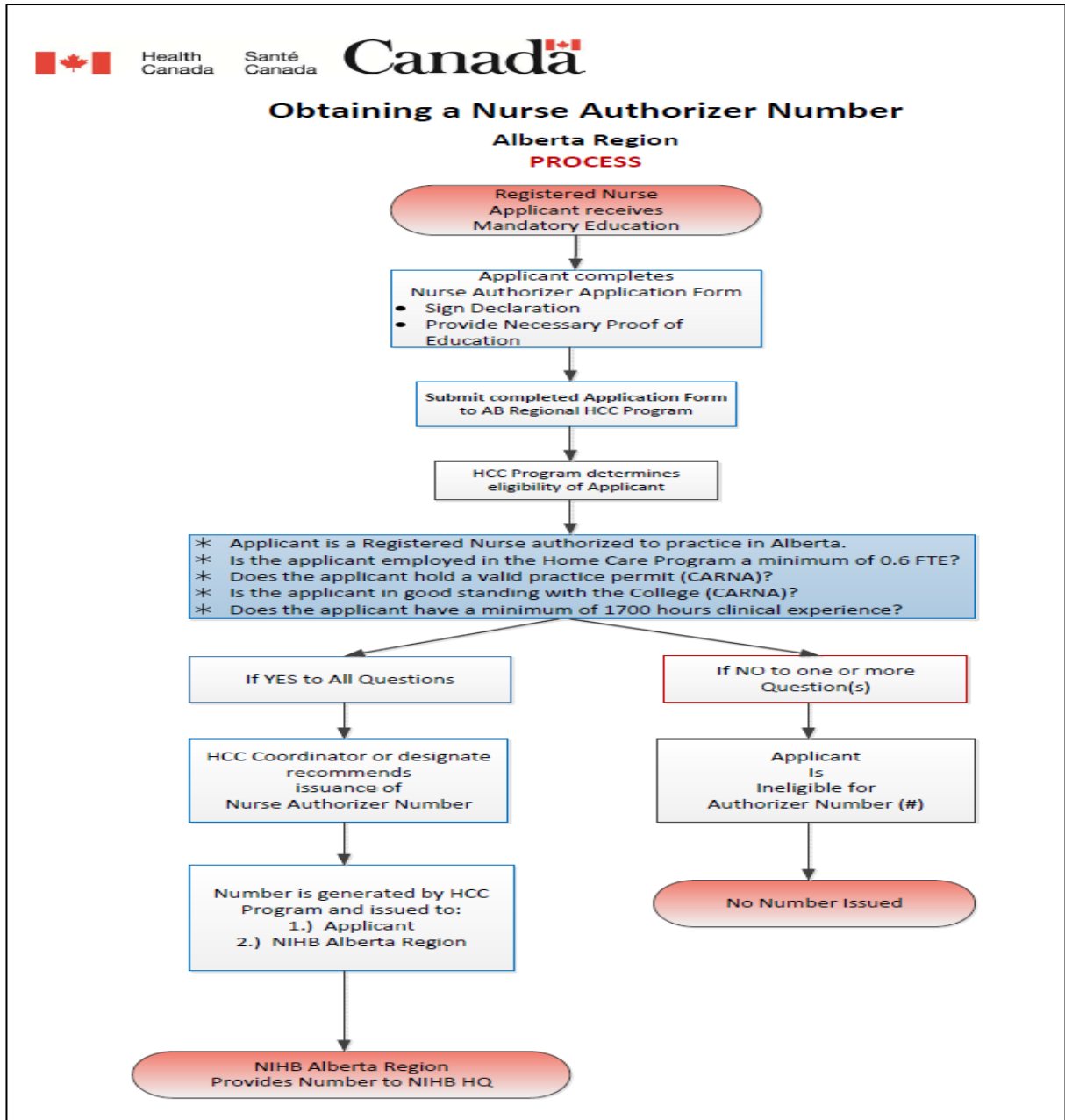
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APPENDIX IV: OBTAINING A NURSE AUTHORISER NUMBER - ALGORITHM






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Related Polices & Procedures: SHS IPAC Policy; SHS Skin Suture, Clip & Staple Removal Policy

APPENDIX V: NURSE AUTHORISER NUMBER APPLICATION FORM

 Alberta NIHB/ Home Care M.S.&E Program Application for Nurse Authorizer Number

Step 1: To be completed by the applicant in the community.
Fax to Regional Home Care Office: 780-495-2687 when Step 1 complete.

Name: _____ Day Phone: _____
 Business Mailing Address: _____ Postal Code: _____
 Fax number: _____ Email: _____

Community(s) in which Nurse Authorizer Numbers are required:
 1. _____ 2. _____ 3. _____

Professional Nursing Registration Number (CARNA Number): _____

Declaration:

Upon signing this application I understand the following:

- I am taking responsibility for the NIHB Nurse Authorizer Number and the acquisition of Home Care Supplies and Equipment for the above mentioned community/communities.
- I have completed all necessary educational requirements as outlined by FNIHB and NIHB and will provide clinical care according to the AHS Wound Care Guidelines, HCCP Standards, and Policies.
- My NIHB Nurse Authorizer Number is not transferable to anyone else.
- The NIHB Nurse Authorizer Number issued will only be valid while I am employed in the above stated community(s) and to be utilized in the care of admitted HCCP clients.
- The NIHB Nurse Authorizer Number issued may be revoked at any time by NIHB upon the advice of the FNIHB Home Care Coordinator.
- I will submit all orders on the most current forms posted on the One Health website.
- All products ordered will be used specifically for the client indicated.
- I am not in a position to directly or indirectly benefit from this process and I have no conflicts to declare.

I agree to the terms and conditions outlined above:

Signature: _____ Date: _____

STEP 2: To be completed by the Regional Nurse Advisor or HCC Practice Consultant.

CARNA number confirmed and applicant is in good standing.
 Applicant is employed at a 0.6 FTE or greater
 Applicant has a minimum of 1700 hrs of clinical practice in Home & Community Care
 Community of practice confirmed.

The applicant has met the above criteria and I am recommending the approval of a NIHB Authorizer Number:
 Signature: _____ Regional Nurse Advisor Date: _____

STEP 3: To be completed by the Regional Home & Community Care Coordinator or Designate

Nurse Authorizer Number(s) issued:

Community	Authorizer Number

Signature: _____ Date: _____

STEP 4: To be approved by the NIHB Manager.

Signature: _____ Date of Approval: _____

Upon approval a copy of the completed form is to be faxed to:
 1. Regional Home & Community Care (780) 495-2687
 2. Applicant

Auth. Number Suspended/Revoked (Date): _____ Signature: _____

Form revised August 2017




STONEY HEALTH SERVICES POLICY AND PROCEDURES

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APPENDIX VI: FOOT CARE ASSESSMENT (AHS)



Alberta Health Services


Diabetes Foot Screening Tool

Affix patient label within this box


EXAM	FINDINGS	R	L	RISK
SKIN	Normal intact skin – healthy or dry			LOW
	Callus/Corn/Fissure/Crack			not bleeding or draining
	Prior history of Diabetic Foot Ulcer(s)			ulcer in remission
	Blister = B			or Hemorrhagic callus = HC
	Fissure or Crack			Bleeding or draining = F
	Diabetic Foot Ulcer – Not infected			and/or with intact dry black eschar = U
	Infected Diabetic Foot Ulcer or wet gangrene			URGENT
NAILS	Normal well-kept with minimal discoloration			LOW
	Missing, sharp, unkept, thickened, long or deformed			MODERATE
	Infected ingrown nail			MODERATE
STRUCTURE ANATOMY	Normal			no noted visual abnormalities
	Decreased range of motion			at ankle or toe joint
	Deformities			Bunion/Hammer or claw toes/overlapping toes
	Structure			Fallen Arch/ Rocker bottom foot/stable Charcot foot
	Previous amputation			X over location or draw/describe on diagram
	Redness over any structural deformities			pressure related
	Red, hot painful joint or acute Charcot foot			URGENT
SENSATION Testing for LOPS	Normal sensation using 10 g monofilament at the 5 predetermined sites			LOW
	Sensation of numbness/tingling/throbbing/burning			MODERATE
	Absent or altered sensation at one or more of the five sites			MODERATE
	Acute onset of pain in a previously insensate foot			URGENT
VASCULAR Testing for Arterial Compromise	Normal pulses			normal capillary refill
	Signs of Ischemia (PAD)			
	Cool skin with pallor, cyanosis or mottling, and/or dependent rubor			HIGH
	One or more pulses not palpable or audible (Doppler)			HIGH
	Absent pedal pulses with cold white painful foot or toes			URGENT
FOOTWEAR	Appropriate accommodates foot shape			LOW
	Inadequate Footwear			MODERATE
	Inappropriate Footwear causing pressure/skin breakdown			HIGH

Instructions: Refer to Health Provider's Guide to Diabetes Foot Screening
Mark ulceration location (U). Mark other areas of specific concern: blister (B), draining fissure/crack (F), hemorrhagic callus (HC), and previous amputation (X).

Sensation Testing (monofilament)



RIGHT



LEFT

Fill in if no sensation ●
Leave blank if sensation present ○

Identify any wounds and location on the foot or toe(s)

Date	Signature	Primary Care Site
Comments		

20710(Rev2017-03)



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APPENDIX VII: ALBERTA FIRST NATIONS HOME CARE PROGRAM DIABETES HIGH RISK FOOT SCREEN

**ALBERTA FIRST NATIONS HOME CARE PROGRAM
DIABETIC HIGH RISK FOOT SCREEN**

Client Name: _____ Band/Inuit I.D.#: _____

Date of Birth: _____ Date: _____

Fill in the following blanks with an "R", "L", or "B" to indicate positive findings on the right, left, or both feet.	YES	NO
Has there been a change in the foot since the last evaluation?		
Is there a foot ulcer now or has there been a history of foot ulcer?		
Does the foot have an abnormal shape?		
Is there weakness in the foot or ankle?		
Are the nails thick, too long, or ingrown?		

ASSESSMENT: For each condition below indicate "P" if present and "A" if absent for each foot. The location and size of the abnormality should be indicated on the feet drawings below.

	RIGHT	LEFT		RIGHT	LEFT
SKIN: Wound/Blisters			VASCULAR: Temperature (warm/cold)		
Callous/Corns			Pulses		
Nails			Capillary refill		
Erythema			Edema		
Other			Varicosities		
SKELETAL: Bunions			NEUROLOGICAL: Strength		
Hammer Toes			Sensation (see below)		
Other					

PROTECTIVE SENSATION: Label each circled area of the foot with a "✓" if the patient can feel the 10 gram (5.07 Semmes-Weinstein) nylon filament and an "✗" if he/she cannot feel the 10 gram filament.

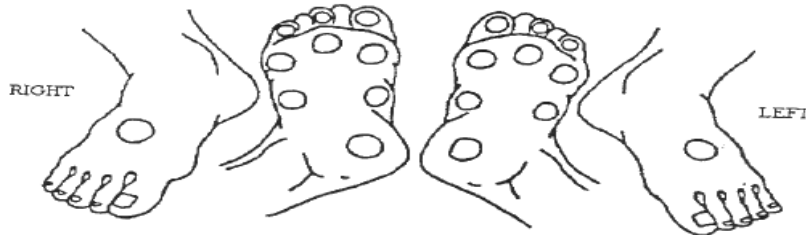


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RISK CATEGORY AND MANAGEMENT

Check "✓" the Risk CATEGORY that is applicable to the Client.

RISK CATAGORIZE	MANAGEMENT CATAGORIZE
CATEGORY 0 - has disease that can lead to insensitivity - protective sensation present - no history of plantar ulcers - no foot deformities	Management CATEGORY 0 - examine feet every visit - test sensation annually * client education
CATEGORY 1 - no sensation in one or more areas - no history of plantar ulcers - no foot deformity	Management CATEGORY 1 - examine feet every visit - test sensation every 6 months - physician referral - client may require corrective shoes, orthotics * client education
CATEGORY 2 - loss of sensation in one or more areas - no history of plantar ulcer - foot deformity, weakness, pre-ulcer, callus is present	Management CATEGORY 2 - examine feet every visit - test sensation every 3 months - physician referral - client may require corrective shoes, orthotics, or prescriptive footwear * client education
CATEGORY 3 - loss of sensation in several areas - has a history of plantar ulcer	Management CATEGORY 3 - examine feet every visit - test sensation every 1 - 2 months - referral to physician - client may require corrective shoes, orthotics, prescriptive footwear * client education

* Client education includes: proper foot care, proper footwear, and proper fitting if shoes.

Other: _____

Signature:

Date:



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APPENDIX VIII: BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK								
Patient's Name _____		Evaluator's Name _____		Date of Assessment _____				
SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.				
NUTRITION <u>usual</u> food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than ½ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
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SKIN & WOUND CARE MANAGEMENT

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APPENDIX IX: BRADEN SCORE INTERVENTION

By the Numbers: Braden Score Interventions

The most commonly used pressure ulcer assessment tool in the United States is the Braden Scale. It consists of 6 subscales: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. It is based on the 2 primary etiologic factors of pressure ulcer development-intensity and duration of pressure (addressed by the sensory perception, mobility, and activity subscales) and tissue tolerance of pressure (addressed by the moisture, nutrition, and friction/shear subscales).

Each subscale within the Braden Scale contains a numerical range of scores, with 1 being the lowest score possible. The friction/shear subscale ranges from 1 to 3; the other subscales range from 1 to 4. The overall Braden Scale score is derived by totaling the numerical ratings from the 6 subscales. The lower the score, the higher the patient's risk for developing a pressure ulcer.

Preventive Protocols

After the total Braden Scale score is computed, a patient's risk and need for preventative protocols can be determined. Because each health care agency may differ in terms of staffing patterns, access to clinicians who specialize in wound care, and the preventative products utilized, it is difficult to prescribe a set of protocols that will fit all circumstances. However, a broad outline of protocol development has been developed.

The following are recommended interventions by Braden Scale score. More specific protocols should be written by each agency, and staff education for use of these protocols must be provided before they are implemented.

At risk: 15 to 18

Consider a protocol of frequent turning; facilitating maximal mobilization; protecting the patient's heels; providing a pressure-reducing support surface if the patient is bedridden or confined to a chair; and managing moisture, nutrition, and friction and shear. If other major risk factors are present (advanced age, fever, poor dietary intake of protein, diastolic blood pressure below 60 mm Hg, or hemodynamic instability), advance to the next level of risk.

Moderate risk: 13 to 14

Consider a protocol of frequent turning; facilitating maximal mobilization; protecting the patient's heels; providing a pressure-reducing support surface; providing foam wedges for 30-degree lateral positioning; and managing moisture, nutrition, and friction and shear. If other major risk factors are present, advance to the next level of risk.

Source: Ayello IA, Baranoski S, Lydcr CH, Cuddigan J. Pressure ulcers. In: Baranoski S, and Ayello KA. Wound Care Essentials: Practice Principles. Springhouse, PA: Lippincott Williams & Wilkins; 2004. p 240 -70.



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High risk: 10 to 12

Consider a protocol that increases the frequency of turning; supplements turning with small shifts in position; facilitates maximal Demobilization; protects the patient's heels; provides a pressure-reducing support surface; provides foam wedges for 30-degree lateral positioning; and manages moisture, nutrition, and friction and shear.

Very high risk: 9 or below

Consider a protocol that incorporates the points for high-risk patients. Add a pressure-relieving surface if the patient has intractable pain, severe pain exacerbated by turning, or additional risk factors such as immobility and malnutrition. A lowair-loss bed is no substitute for a turning schedule.

Patient Care Tips

The following suggestions can help the clinician manage the patient's moisture, nutrition, and friction and shear.

Managing moisture

Use a commercial moisture barrier, and use absorbent pads or diapers that wick and hold moisture. Address the cause of moisture if possible, and offer a bedpan or urinal and a glass of water in conjunction with turning schedules.

Managing nutrition

Consult a dietitian and act quickly to alleviate nutritional deficits. Increase the patient's protein intake and increase his or her calorie intake if needed. Provide a multivitamin containing vitamins A, C, and E.

Managing friction and shear

Elevate the head of the bed no more than 30 degrees and have the patient use a trapeze when indicated. Use a lift sheet to move the patient. Protect the patient's elbows, heels, sacrum, and back of the head if he or she is exposed to friction.

Other general care issues

Do not massage reddened bony prominences and do not use donut-type devices. Maintain good hydration and avoid drying out the patient's skin.

Source: Ayello IiA, Baranoski S, Lyder CH, Cuddigan J. Prossure ulcers. In: Baranoski S, and Ayello KA. Wound Care Kssentials: Practice Principles. Springhouse, PA: Lippincott Williams & Wilkins; 2004. p 240 -70.]



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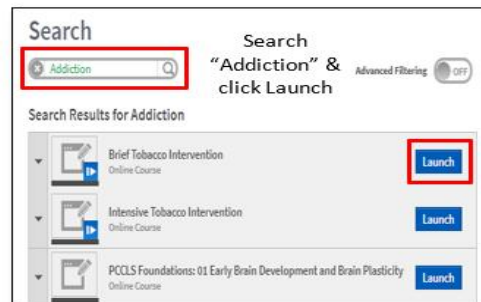
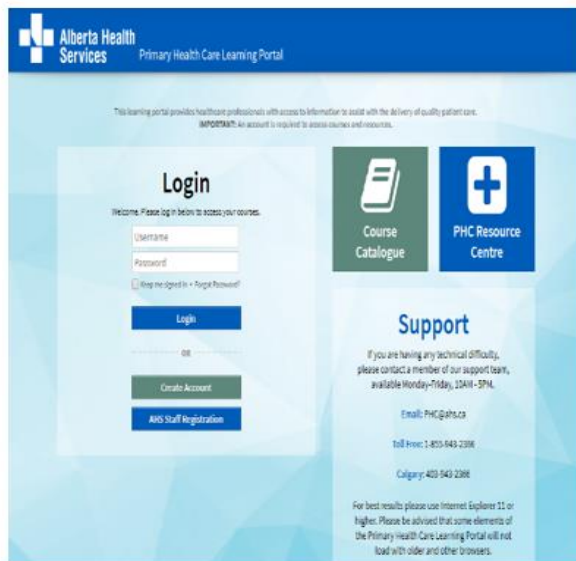
APPENDIX X: USING THE PRIMARY HEALTH CARE LEARNING PORTAL

The Primary Health Care Learning Portal is designed for health care providers working outside of Alberta Health Services (AHS). Also known as “PHC Absorb,” this learning portal hosts a variety of courses from programs such as AIM Alberta, Addictions and Mental Health and Chronic Disease Management. There are 2 ways to access this portal.

1. CREATE YOUR OWN ACCOUNT:

Set up your own account in four easy steps. *Start here*
<https://phc.myabsorb.ca>

- A. Click “Create Account.”
- B. Fill out the form to become a member of the Primary Health Care Learning Portal.
- C. Use the search feature within the system to locate the courses you seek specifically or go to Catalogue to see what is available.
- D. Enroll in /Launch the course you wish to take.





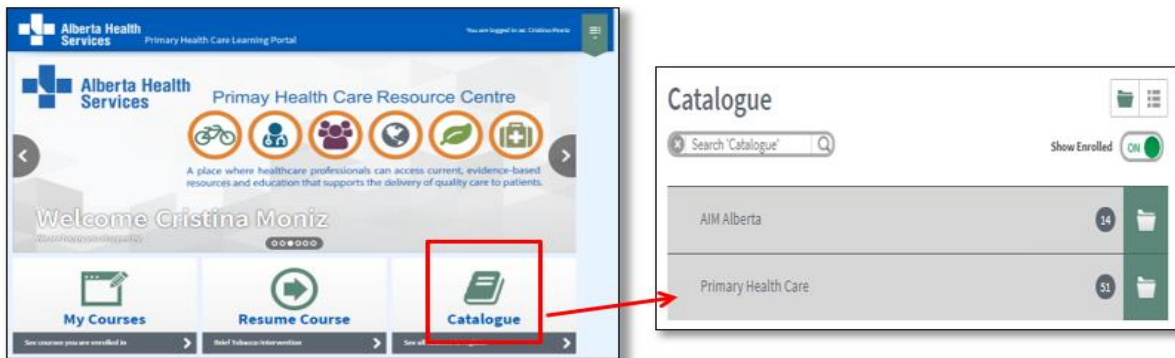
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2. USE THE CATALOGUE



- A. A confirmation email will be sent to you after creating an account.
- B. Please keep this on file to remember your own personal login and password.
- C. You may also print your transcripts to show completion of courses. This option is located from the main page.



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