1. SCOPE

1.1. Marshfield Clinic System Wide Telepresenters

2. DEFINITIONS & EXPLANATIONS OF TERM

2.1. **Sharp/ Surgical Debridement**: Includes the use of a scalpel, forceps, scissors, hydro surgery devices, or lasers to remove dead tissue. Debridement is required to convert the chronic wound bed into an acute wound so that the wound healing cascade can get a fresh start. Sharp debridement is considered the “gold standard” by clinicians. It can also cause pain so a topical anesthetic is such as lidocaine gels or creams may be required.

2.2. **Wound Debridement**: The removal of dead, damaged, or infected tissue to improve the healing potential of remaining healthy tissue.

2.3. **Biofilm**: Is essentially an invisible “layer” formed by an extracellular matrix that binds to the wound base, whether dermis, fascia, muscle, tendon, or bone.

2.4. **Acute Wounds**: Normally wounds proceed through an orderly process that results in sustained restoration of anatomic and functional integrity.

2.5. **Chronic Wounds**: Have failed to proceed through an orderly and timely process to produce anatomic and functional integrity, or proceed through the repair process without establishing a sustained anatomic and functional result.

2.6. **Actively Infected Wounds**: Contain surrounding erythema, swelling, induration, tenderness, purulence and malodor.

2.7. **Chronically Inflamed Wounds**: May have a rim of surrounding erythema, even without other local clinical signs of infection.

2.8. **Tissue forceps**: Helpful in grasping the tissue.

2.9. **Scalpels**: Used to slice off thin layers of tissue.

2.10. **Curettes**: Useful in removing the biofilm that accumulates on top of both fresh and chronic granulation tissue.

2.11. **Bone Rongeurs**: Useful for removing hard-to-reach soft tissue and for debriding or taking biopsy of bone.

2.12. **Wound Assessment**: Is written record and picture of the progress of the wound—is a cumulative process of observation, data collection, and evaluation.

2.13. **Edema**: The presence of shiny, taut skin or pitting impressions in the skin adjacent to the ulcer but within 4 cm from the ulcer margin.

2.14. **Edema Assessment**:
   - 1+= slight pitting: no visible change in the shape of the leg (skin indents 2mm).
   - 2+= somewhat deeper pitting: no marked change in the shape of the leg...
2.15. **Drainage Assessment:** Is the exudate. Be sure to note amount, color and odor.

2.16. **Exudate:** Is the accumulation of fluids in the wound, which may contain serum, cellular debris, bacteria, and leukocytes.

2.17. **Serous exudate:** Is clear or pale yellow.

2.18. **Serosanguinous exudate:** Is blood tinged serous fluid.

2.19. **Pulse Assessment:** Assess for strength (i.e. absent/present, equal) and/or a three point scale of: 3+= bounding, hyperkinetic, 2+= normal, 1+= weak, thready, hypokinetic, 0= absent; Regularity: regular or irregular; Equality: bilaterally are the pulses equal or not.

2.20. **AgNO3:** Silver nitrate to assist in hemostasis.

2.21. **SurgiCel:** Is a hemostatic agent (blood-clot-inducing material) made of an oxidized cellulose polymer.

2.22. **Hemostasis:** The stopping of bleeding or hemorrhaging in an organ or body part.

2.23. **Granulation:** The formation of tissue in the wound base.

2.24. **Erythema:** The presence of bright or dark red skin or darkening of ethnic skin color immediately adjacent to the ulcer opening.

2.25. **Epithelialization:** To become, or cause a part of the body to become, covered with epithelial tissue, as in the healing of a wound.

2.26. **Undermining:** Is tissue destruction that occurs around the wound perimeter underlying intact skin, in these wounds, the edges have pulled away from the wound base.

2.27. **Induration:** Abnormal firmness of tissues with margins.

2.28. **Fluctuance:** Wavy impulse felt in palpitation and produced by vibration of body fluid.

2.29. **Sinus tract (tunneling):** Is a channel that extends from any part of the wound and may pass away from the wound through subcutaneous tissue and muscle.
2.30. **Fistulas:** Connects viscous organs together (for example, rectovaginal fistula), or connect to the skin (for example, enterocutaneous fistula).

2.31. **Maceration:** Is a softening of the skin surrounding a wound due to excess drainage or pooling of fluid on intact skin and appears as white, waterlogged area.

2.32. **Slough:** Necrotic tissue that is moist, stringy, and yellow.

2.33. **Eschar:** In a wound that has become dehydrated, necrotic tissue turns thick, leathery, and black.
2.34 **Geography of Chronic Wounds:** A+B+C= The Total Wound
- **A**= The wound bed
- **B**= The wound edge
- **C**= Is the surrounding skin

2.35 **Partial Thickness wounds:** Refers to as damage to the epidermis and part of the dermis. Common examples are abrasions, skin tears, blisters, and skin-graft donor sites.

2.36 **Full Thickness wounds:** Extend through the epidermis, dermis, and may extend into the subcutaneous tissue, fascia, and muscle.

2.37 **Macro Pictures:** Taking picture of the whole body part in relation to the wound.

2.38 **Micro Pictures:** Taking pictures of just the wound.

2.39 **Codec:** refers to the use of clinical video systems.

3. **PROCEDURE BODY**

The following document provides direction for telehealth presenters responsible for the presenting of patients to Wound Healing Services or any provider who may need a component of Wound Healing history or physical exam shall be proficient in providing Wound Healing exam data via Telehealth technologies while working within scope of practice.

3.1 **Pre-Consult Preparation**
   - a. Prepare technology according to [Core Telepresenting Procedure](#), including Doppler and Digital Camera.
   - b. Prepare wound supplies (i.e. normal saline, roll gauze, 4x4’s, debridement supplies).
c. Complete vital signs to include: temperature, pulse, blood pressure and respirations. Enter results in dashboard under Clinical Observation. Be sure to select the appropriate provider and the necessary package that coincides with the visit.

3.2. **Pre-Exam Patient Preparation:**

a. **Step 1:** The Telepresenter Dons gloves.

b. **Step 2:** Position patient comfortably on the exam table. Be conscious not to overexpose the patient.

c. **Step 3:** Remove wound dressing and packing. Remove the dressing without ripping, tugging, or tearing off a dressing stuck to the wound. Place in disposable infectious waste bag.

3.3 **Clinical Assessment:**

a. Please see [Telehealth Wound Documentation Procedure](#) for required clinical assessment and documentation findings.

b. Perform edema assessment.

c. **Please note:** pulses must be checked laying down and not in a wheel chair. If not palpable, use Doppler to check pulses. If a Doppler is used, the provider will want to hear the quality of the pulse during the consult.

d. If wound is on the legs, measure the calf four inches below the bottom of the patella. Ankle measurements should also be documented. Measure both legs and ankles for comparison.

e. **PLEASE NOTE:** All measurements should be in centimeters.

3.4 **Cleansing the wound:**

a. Clean around the wound with a mild soap and water. Pat dry.

b. Clean wound using normal saline and to loosen a dressing that has adhered to the wound.

c. Debride wound of any crusting or callus. Please refer to [Wound Debridement Procedure](#).

d. Cleanse the wound bed and the surrounding skin after debridement with normal saline.

3.5 **Wound Measurement:** Look carefully at wound edges to determine whether they are distinct, to ensure accurate measuring of wound edges. Take the following steps:
a. **Step 1:** To establish an anatomic landmark; identify the location of the patient’s head and always mark the 12:00 at the patient’s head regardless of the position of the patient. Continue to mark for 3:00, 6:00, and 9:00 accordingly.

b. **Step 2:** Measure wound edge to wound edge starting with the 12:00 -6:00 edge, then measuring 3:00-9:00 edge at the longest point.

c. **Step 3:** Measure depth of the wound using a moistened cotton tip applicator, place into the depth of the wound to be measured, grasp the applicator at the level of the skin. While still grasping the applicator, remove from the wound and place next to disposable wound measurement ruler. Measure undermining if present.

3.6. **With a digital camera take macro and micro distribution pictures of the wound.**

   a. E-mail the pictures securely to the provider and the MA/Tech working with him/her.

   b. Delete pictures from the digital camera after provider has what they want.

3.7. **Document Findings:**

   a. Prepare a document in Document Manager under your work list labeled Telehealth Patient Note. The document is a Structured Document. Using the Nursing Assessment Macros, and Additional Wound Macros if needed, document findings according to section 3.3 a.

3.8. **Assist Provider with Physical Exam:**

   a. When the provider states they are ready to view the wound, use the hand held video camera to show location/ distribution and close ups of the wound.

   b. Obtain cultures as directed by the provider. Please see Telehealth
Wound Culture Collection Procedure

3.9. Post Physical Exam Considerations:

a. Refer to Core Telepresenting Procedure for details
b. Assist with follow up appointments.
c. If prescriptions are needed, the patient will obtain from Wound Healing Provider via standard e-prescribing procedures.

4. ADDITIONAL RESOURCES

4.1. References:


4.2. Supporting documents available:
- State summary:
- To Access Document Manager:
- Technology Report Form:
  http://srdweb1/clinic/iqips/Telehealth/technology/TH_technology.html
- Telehealth Wound Documentation
- Telehealth Wound Culture Collection
- Telehealth Wound Debridement

5. DOCUMENT HISTORY

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<thead>
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<th>Version No.</th>
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When document is printed it becomes an uncontrolled copy. Please refer to DCS system for most current version.
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Section 2: Added definitions and pictures.
Section 3.3: Added hyperlink to clinical documentation.
Section 3.3: Added pictures.
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Section 4.2: Added link to sharp debridement in Wisconsin.

6. DOCUMENT PROPERTIES

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