Conservative Sharp Debridement Non-Viable Tissue

Procedure Performed by: ☐ RN ☐ LPN ☐ NP ☐ PT ☐ PTA

Purpose

This document provides procedures for the debridement of wounds to remove eschar and nonviable tissue in chronic wounds.

Audience

A physician's order is required prior to initiating the procedure.
A wound assessment shall be done to assess for appropriateness of debridement.
Aseptic technique shall be utilized to prevent and control infection. Personnel shall wear gloves during the procedure. Masks, gowns, and caps will also be used when appropriate.
Debridement shall be done using sterile forceps, scissors, and scalpel.

Indications:

- Situations where rapid debridement is imperative
- Signs of advancing cellulitis

Contraindications:

- Systemic Infections
- Arterial Insufficiency
- Clotting disorders
- Viable tissue

Equipment

- 4x4's
- sterile scissors
- sterile forceps
- sterile scalpel
- gown, masks, caps, gloves
- bio-hazard trash bag
- Cover Dressings/Treatment

Frequency

Perform LOI per facility or agency policy. Arterial perfusion may deteriorate over relatively short periods; reassess every 3 months or more frequently if the clinical situation indicates a change.

Procedure

1. Verify physician's order.
2. Identify patient/resident.
3. Wash hands.
4. Perform wound assessment. Verify wound appropriate for sharp debridement.
5. Determine patients level of sensation in wound and periwound area.
6. Medicate patient prior to the procedure with pain medication as necessary.
7. Inform patient/family of procedure and expected outcome.
8. Provide privacy.
9. Wash hands.
10. Establish a sterile field.
11. Assemble and prepare equipment. Open packages of sterile 4x4's and other sterile supplies. Open and place bio-hazard trash bag in accessible area.
13. Provide adequate lighting.
14. Position patient/resident in comfortable position for debridement.
15. Apply non-sterile gloves, remove old dressing and discard.
16. Remove gloves

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17. Wash Hands.
18. Apply non-sterile gloves. (Unless order calls for sterile gloves)
19. Cleanse area with normal saline or ordered cleanser.
20. Cut eschar with scalpel if indicated.
21. Use pick-up forceps to left or remove non-viable tissue. Use scalpel to cut tougher nonviable tissue. Use sharp scissors as indicated.
22. Discard non-viable tissue in appropriate bio-hazard contaminate bag.
23. Carefully cut necrotic tissue, where indicated, in layers to prevent damage of underlying viable tissue.
24. Remove as much non-viable tissue as possible.
25. If bleeding should occur, stop debridement, apply sterile 4x4's and pressure to the area will be used for control. If the bleeding persists after ten minutes of constant pressure, a pressure dressing must be applied and the physician notified. The pressure dressing is checked at least every fifteen minutes until the bleeding stops.
26. If pain increases, stop debridement and institute appropriate intervention.
27. After completion of debridement, cleanse wound again with normal saline/cleanser.
28. Re-measure and assess wound.
29. Apply appropriate topical agent/dressing as ordered per non-sterile dressing change procedure.
30. Remove gloves and discard.
31. Label dressing with date, time, and initials.
32. Assist patient/resident to comfortable position with call light within reach.
33. Wash hands.
34. Document procedure and assessment.

Documentation

- Date time debridement done
- Summary of procedure
- Wound assessment: measurements, drainage, wound bed, etc (after debridement)
- Problems encountered during assessment
- Patient tolerance to procedure
- Type of analgesia implemented
- Pain assessment
- Patient/resident/family teaching
- Type of wound dressing applied
- Plan for further interventions
- (CPT codes #97601 selective debridement and #97602 non-selective debridement)

Source: Bill Richlen PT, WCC, DWC, and Denise Richlen PT, WCC