

SUBJECT: PHOTOGRAPHING/VIDEOTAPING PATIENTS	REFERENCE #1004
DEPARTMENT: ORGANIZATIONWIDE	PAGE: 1 OF: 4
APPROVED BY:	EFFECTIVE: REVISED:

POLICY:

- It is the policy of this facility to take photographs and/or film or video tape in an effort to assist educational, treatment, research, scientific, public relations and charitable goals of the institution; and to document certain physical conditions when it may be of benefit to the patient's plan of care and treatment.
- Photographs, films and/or videotape made for the purposes of identification, diagnosis or treatment of the patient do not require patient consent.
- Photography, filming or videotaping to be used internally by the organization for educational or operational purposes (i.e., performance improvement, education) require consent of the patient or his/her authorized legal representative. The consent for photography, filming or videotaping for these reasons will be listed as a component of the general consent for treatment and services provided to, and signed by the patient upon admission to the facility.
- All photographs, films and/or videotape taken for external educational, research, scientific, public relations and/or charitable goals of the institution will be utilized only with the express permission and consent of the patient or his or her legally authorized representative by hospital staff, physicians, healthcare professionals and authorized members of the public for the purposed listed above. A distinct and separate consent for photography, filming or videotaping for these reasons must be documented as obtained from the patient or his/her authorized legal representative.
- This institution will maintain the interrelated goals (as they relate to photographing/filming/ videotaping of the patient's healthcare process) of protection of patient privacy and informing the public to better understand healthcare, in the highest regard.

PROCEDURE:

- The patient or his or her legal representative shall sign a "Authorization and Consent Photograph and Publication" consent form for photography, filming or videotaping for reasons other than patient identification, diagnosis or treatment:
 - If conscious and mentally competent, the patient is required to give consent to be photographed, filmed or videotaped.

SUBJECT: EMERGENCY WOUND MANAGEMENT	REFERENCE #2116
DEPARTMENT: ORGANIZATIONWIDE	PAGE: 1 OF: 3
APPROVED BY:	EFFECTIVE:
	REVISED:

POLICY:

- In the event of a flood disaster, healthcare professionals at _____ Hospital will follow basic wound management protocol.
- _____ Hospital staff will ensure their own safety as well as the safety of the patient.
- Standard Precautions will always be followed.

PROCEDURE:

- Initial Wound Treatment:
 - Obtain a focused history from the patient. Perform an appropriate examination to exclude additional injuries.
 - Apply direct pressure to any bleeding wound to control hemorrhage.
 - The use of a tourniquet is rarely indicated since it may reduce tissue viability.
 - Examine the wound for:
 - Gross contamination
 - Devitalized tissue
 - Foreign bodies
 - Remove constricting rings or jewelry from injured body parts, if possible.
 - Cleanse the wound periphery with soap and sterile water or available solutions.
 - Provide anesthetics and analgesia, whenever possible.
 - Irrigate wounds with saline solution using a large bore needle and syringe. If saline solution is not available, use bottled water.

SUBJECT: PRESSURE ULCER PREVENTION PROGRAM	REFERENCE #2124
DEPARTMENT: LONG TERM CARE	PAGE: 1
	OF: 9
APPROVED BY:	EFFECTIVE:
	REVISED:

DEFINITION:

- A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers. Pressure ulcers can occur whenever pressure has impaired circulation to tissue. Pressure ulcers develop when soft tissues are compressed between a bony prominence and the surface of an object, i.e., mattress, seat of a chair, catheter compressed between a resident’s thighs.
- Pressure ulcers are usually located over a bony prominence, such as the sacrum, heel, the greater trochanter, ischial tuberosity, fibular head, scapula and ankle.
- Pressure ulcers are described as:
 - Stage I Non-blanchable erythema of intact skin is the heralding lesion of skin ulceration. Discoloration of skin, warmth, edema or hardness, pain or itching may be indicators of a pressure ulcer in residents. These indicators will be evident after the pressure on the area has been removed for 30-45 minutes.
 - Stage II Partial thickness skin loss involves epidermis and/or dermis. The ulcer is superficial. The ulcer presents clinically as an abrasion, blister or shallow crater.
 - Stage III Full-thickness skin loss involves damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
 - Stage IV Full thickness skin loss with extensive destruction, tissue necrosis or damage to fascia, muscle, bone or supporting structures (i.e., tendon, joint capsule) is involved. Sinus tracts and undermining may be present.
- Note that some evidence suggests that it may be harder to identify erythema in an older adult with darkly pigmented skin. For dark-pigmented individuals, assess signs of skin discoloration as well as evidence of pressure ulcer development, such as bogginess, induration, coolness or increased warmth.

SUBJECT: SKIN TEARS	REFERENCE #3130
DEPARTMENT: ORGANIZATIONWIDE	PAGE: 1
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APPROVED BY:	EFFECTIVE:
	REVISED:

DEFINITION:

- A skin tear is a traumatic wound resulting when the epidermis is separated from the dermis.
- Skin tears can occur when lifting, turning or transferring a patient, when removing tape or an adhesive dressing from a patient's skin or when a patient bumps into an object.
- Research has shown the skin tears occur more frequently in the upper extremities.

POLICY:

- Precautions will be taken by nursing staff to prevent skin tears from occurring.
- Precautions may include:
 - Following proper positioning, turning and transfer protocols
 - Ensuring bedrails, wheelchair arms and leg supports are padded
 - Encouraging patients to wear long sleeves and pants to add another layer of protection to skin
 - Using paper tape on frail skin; use nonadhesive dressings on frail skin
 - Use gauze, kling, stockinettes to secure dressings and drains
 - Removing tape and adhesive dressings carefully (See Removing Tape From a Patient's Skin policy and procedure).
- Do not scrub a patient's skin during a bath.
- Do not use alcohol solvents which are drying to the skin.
- Implement your organization's fall prevention program.
- Provide continuous education of staff.

SUBJECT: WOUND ASSESSMENT AND REASSESSMENT	REFERENCE #3133
	PAGE: 1 OF: 5
DEPARTMENT: ORGANIZATIONWIDE	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- It is the policy of this organization that each patient admitted shall receive a complete head-to-toe assessment by a qualified individual so that a plan of care can be developed to best meet the needs of the patient. The assessment of the care or treatment required to meet the needs of the patient will be ongoing throughout the patient's hospital stay, with the assessment process individualized to meet the needs of the patient population.
- Skin assessment is a component of the initial assessment. If it is determined, at the time of admission, that the patient is at high risk for developing a wound or if the patient is admitted with a wound, further assessment will be completed by a Wound Care RN.
- The scope and intensity of any further assessments are determined by the patient's diagnosis, treatment setting, patient's desire for treatment, patient's response to previous treatment and the patient's compliance with the treatment plan.
- The frequency of wound assessment is also determined by the healthcare setting:
 - Acute care: wound assessment occurs every day or at dressing changes
 - Long term care: on admission and weekly
 - Pressure ulcers:
 - ◆ The resident's risk for developing a pressure ulcer will be reassessed throughout the resident's hospitalization.
 - ◆ The resident at risk will be reassessed weekly for the first four (4) weeks after admission and then quarterly thereafter.
 - ◆ The resident will be assessed whenever there is a change in the resident's cognition or functional ability.
 - Home Healthcare: according to schedule home visits
- Upon completion of the initial admission assessment, an individualized prioritized plan of care will be developed in consultation with the patient/significant other.