STANDARDIZED PROCEDURE
CLOSING A WOUND (Adult, Peds)

These procedures are intended to describe procedures performed by Nurse Practitioners and/or Certified Nurse Midwives (depending on the clinical privileges granted to the individual practitioner) at UC San Diego Health.

I. Definition

This procedure is to allow the Advanced Health Practitioner to safely close wounds and takes place when a drain is removed, when a suture line needs reinforcement or for other wound closures.

II. Background Information

Setting: The setting (inpatient vs outpatient) and population (adults vs pediatrics) for the Advanced Health Practitioner (AHP) is determined by the approval of the privileges requested on the AHP Privilege Request Form. If the procedure is being done on a Pediatric patient, make sure Child Life is involved and use age appropriate language and age appropriate developmental needs with care of children, as appropriate to the situation.

Supervision

The necessity of the procedure will be determined by the Advanced Health Practitioner in collaboration with the attending physician or his/her designee. Designee is defined as another attending physician who works directly with the supervising physician and is authorized to supervise the Advanced Health Practitioner. Direct supervision will not be necessary once competency is determined, as provided for in the procedure. The Advanced Health Practitioner will notify the physician immediately under the following circumstances:

1. Patient decompensation or intolerance to the procedure
2. Drainage that is not resolved
3. Outcome of the procedure other than expected

Indications

To repair surgical and traumatic disruptions of skin or tissue that will not heal naturally.

Precautions/Contraindications (relative)

- Clinical risk factors for poor healing
- Dirty and infected wounds
- Contaminated wounds
- Malnutrition
- Diabetes
- Sepsis
- Chemotherapy

- Immuno-suppression
- Peripheral vascular disease
- Obesity
- Radiation therapy
- Edema
- Foreign bodies
- Tension on wound edge
- Pressure over a bony prominence

III. Materials

- Anti-septic solution (i.e., Chlorhexadine)
- Smooth or multi-tooth forceps
- Needle holder
- Scissors
- Sterile gloves
- Sutures
- Needles
- Injectable anesthetic (i.e. lidocaine)
- Non-adherent dressing
- Antibiotic ointment
- Tape

IV. Procedure

Pre-treatment evaluation

Review contraindications and patients current clinical condition.

Patient Preparation

1. Identify the patient using two patient identifiers. Inform the patient of the treatment plan, which includes wound closure. Address any questions or concerns.
2. Position the patient in a comfortable position that allows full visualization of area to be closed.

Perform Procedure

1. Verify that the patient is not allergic to iodine or local anesthetics.
2. Clean the wound with Chlorhexadine solution in a circular pattern from the wound edges outward
3. Anesthetize the skin along each side of the wound if necessary.
4. Using dominant hand, grasp the suture needle securely with the needle holder. Use a toothed forceps in other hand to stabilize the wound edge in a slightly averted position.
5. Insert the needle at a right angle through the skin about ¼″ to ¾″ from the wound edge. Grasp the needle from the exterior with the needle holder. Before inserting the needle again, be sure the tissue layers are well approximated with minimal tension.
6. Repeat the process and then tie the suture, being careful not to pull the suture edges too taut.

7. After suturing the wound, compress wound gently and look for residual bleeding. Use direct pressure for 5 minutes to minimize swelling and bleeding from the wound edge.
8. Cover suture line with a thin layer of antibiotic ointment.

Follow-up treatment

Instruct the patient on wound care, as needed, and on signs and symptoms of infection.

V. Documentation

A. Documentation is in the electronic medical record

1. Documentation of the pretreatment evaluation and any abnormal physical findings.
2. Record the time out, indication for the procedure, procedure, type and size of materials used, EBL, the outcome, how the patient tolerated the procedure, medications (drug, dose, route, & time) given, complications, and the plan in the note, as well as any teaching and discharge instructions.

B. All abnormal or unexpected findings are reviewed with supervising physician.

VI. Competency Assessment

A. Initial Competence

1. The Advanced Health Practitioner will be instructed on the efficacy and the indications of this therapy and demonstrate understanding of such.
2. The Advanced Health Practitioner will demonstrate knowledge of the following:
    - Medical indication and contraindications of closing a wound.
    - Risks and benefits of the procedure
    - Related anatomy and physiology
    - Consent process (if applicable)
    - Steps in performing the procedure
    - Documentation of the procedure
    - Ability to interpret results and implications in management.
3. Advanced Health Practitioner will observe the supervising physician perform each procedure once and perform the procedure three times under direct supervision.
4. Supervising physician will document Advanced Health Practitioner's competency prior to performing procedure without direct supervision.
5. The Advanced Health Practitioner will ensure the completion of competency sign off documents and provide a copy for filing in their personnel file and a copy to the medical staff office for their credentialing file.

B. Continued proficiency

1. The Advanced Health Practitioner will demonstrate competence by successful completion of the initial competency.

2. Each candidate will be initially proctored and signed off by an attending physician. Advanced Health Practitioner must perform this procedure at least three times per year. In cases where this minimum is not met, the attending, must again sign off the procedure for the Advanced Health Practitioner. The Advanced Health Practitioner will be signed off after demonstrating 100% accuracy in completing the procedure.
3. Demonstration of continued proficiency shall be monitored through the annual evaluation.
4. A clinical practice outcomes log is to be submitted with each renewal of credentials. It will include the number of procedures performed per year and any adverse outcomes. If an adverse outcome occurred, a copy of the procedure note will be submitted.

VII. RESPONSIBILITY

Please contact the Advanced Practice Council if you need help. The administrative assistant for the Chief Nursing Officer can direct you. Call; 619-543-3438.

VIII. HISTORY OF POLICY

Revised by the Committee of Interdisciplinary Practices: 2/26/2014, 9/28/2016

Reviewed by the Medical Staff Credentials Committee: 3/5/2014, 10/6/2016

Approved by the Medical Staff Executive Committee: 3/20/2014, 10/7/2016