Negative Pressure Wound Therapy (NPWT) - Procedure

Implementation- Action/Rationale

	Action		Rationale
1.	Check with manufacturer, obtain physician orders and have Negative Pressure Wound Therapy (NPWT) Representative assist on first visit to home.	1.	Assures that all procedures follow manufactures recommended guidelines and Physician orders are followed.
2.	Explain procedure to client.	2.	Informs client of what to expect, thereby reducing stress and fears.
3.	Wash hands/provide hand hygiene.	3.	Removes microorganisms.
4.	Gather equipment/supplies. Place on clean work area. May open supplies.	4.	Provides efficient time management.
5.	Don gloves, apron and goggles if needed.	5.	Provides increased protection against microorganisms.
6.	If the NPWT device is already in place, raise the tubing connectors above the level of the therapy unit. Tighten clamp on dressing tubing, separate canister tubing and dressing tubing by disconnecting the connector. Allow the unit to pull the drainage in the canister tubing into the canister then tighten clamp on the canister tubing. Turn unit off. Gently stretch occlusive dressing horizontally and slowly pull up from skin. Do not peel. Carefully remove foam from wound. Discard dressing and soiled gloves.	6.	Provides best method of disconnecting tubing, reducing spillage of drainage. Pulling dressing horizontally will reduce skin irritation and possible damage to periwound skin. Following protocol to discard dressing and soiled gloves reduces the likelihood of contaminating self, client, and work area.
7.	Perform hand hygiene and put on clean gloves. (Sterile gloves if ordered.)	7.	Reduces spread of microorganisms.
8.	Clean wound with saline or ordered solution. (Check with manufacturer to make sure solution is compatible with type of dressing/packing.) Clean and dry periwound tissue. Take initial wound photograph and follow with weekly photographs per agency policy. May apply skin prep if ordered. Note wound size and pathology, select appropriate foam. (Initially, this may be done by NPWT Representative and Physician. When possible, the NPWT Representative should go on first visit with nurse, to assist with application of device.) Cut the foam to allow foam to fit gently into wound. After initial visit, follow ADPH Policy on wound measurements unless MD orders more frequently.	8.	Assures MD orders and manufacturer recommended guidelines are followed. The cleaning and prepping of periwound tissue protects the skin and aids in dressing adherence. Selecting proper foam and size will maximize wound healing. Placing the foam gently into the wound bed will help to prevent undue pressure in wound and will help with healing. Measurements of wound record client's progress or lack of progress.
9.	Place foam into wound, covering the entire wound bed and sides. If more than one foam piece is used, the nurse should count, document in chart, and on outside of dressing, the number of	9.	Covers all areas of wound and will assure insertion and removal of same number of foam pieces. Even distribution of negative pressure to maintain optimum wound healing.

	foam pieces used. If more than one foam piece is used, be sure that each piece is touching the other to maintain even distribution of negative pressure and improve adherence.		
10.	Size and cut the occlusive dressing to cover the foam dressing as well as an additional 3-5 cm border of intact periwound tissue. Save any excess dressing. May keep excess to repair dressing if there is a leak. If the periwound area is not intact, the nurse may need to create a frame around the tissue with a hydrocolloid type dressing. Check with MD for order. If dressing to protect the periwound is ordered, the occlusive dressing will need to be cut large enough to cover both the foam and the hydrocolloid.	10.	Assures complete coverage to optimize adherence of dressings. Framed dressing around irritated or non-intact skin will help to protect delicate tissue.
11.	For the **classic, traditional systems**: Apply the tubing to the dressing. Cut a hole through the occlusive dressing and into the foam. Insert tubing into the hole that is in foam and occlusive dressing and secure with an additional occlusive dressing. Tubing must be placed away from bony prominences at all times. For the **T.R.A.C. type pads (small circular pad with tube attached)**: After performing steps 1-10, cut a 2 cm hole in the occlusive dressing, large enough to allow fluid to flow through the dressing. Lift the drape with your fingers and cut the drape. **There is no need to cut the foam**. Apply the T.R.A.C. type pad opening directly over the hole in the occlusive dressing. Press and apply gentle pressure over the dressing to assure adherence. Avoid tubing placement over bony prominences, or in creases of the tissue/body. Note: be sure that you cut a circular hole and not just a slit. A slit will collapse and not allow proper drainage of fluids and will prevent negative pressure from being applied. **Note: There are other types of NPWTdressings available. Please follow recommended guidelines and consult with the NPWT device Representative/Physician.**	11.	Supplies negative pressure to the wound. Avoiding bony prominences avoids undue pressure to any area. Assures that the manufacture guidelines are followed for each specific type of wound and NPWT dressing.
12.	Remove canister from package and insert canister into the NPWT unit. A click should be heard.	12.	A click indicates that the canister is properly inserted.

13.	Connect the dressing tubing to the canister tubing. Open all clamps. Place the NPWT device unit on a level surface. Set options on unit as determined by physician or the NPWT device Representative. (Options are: cycle and target pressure, which is set up on first visit that is made with Representative to patient's home.)	13.	Assures proper connection. Alarm will sound if unit is not level. Placing the unit on the ordered cycle and pressure assures client receives treatment as ordered.
14.	Activate unit by pushing On/Off power button. A green light will come on. Dressing should collapse in less than one minute. If the dressing fails to do so, there may be a leak. Listen for a whistling sound. Press dressing to guarantee adherence. Repair of leaks may be needed utilizing the excess occlusive dressing.	14.	The green light confirms unit is on. Complete collapse of the dressing and no whistling confirms suction is on with no leaks.
15.	Change dressing every 48 hours or 3 x week. If wound has infection, it is recommended to change dressing every 12-24 hours. **Tip:** when changing dressing: If dressing adheres to the wound, moisten it with saline or approved solution, prior to removal. Allow solution to set (soak) for 15 to 30 minutes before re-attempting to remove.	15.	Changing dressing per protocol is done for optimum healing**.**
16.	Wash hands/perform hand hygiene. Document procedure and client's tolerance of procedure. Notify MD of any abnormal findings. Refer all patients with NPWT to the Wound Specialist through Wound Advisor in the Horizon documentation system.	16.	Reduces the chance of spreading microorganisms. Records all information needed for continuity of care. Informs MD of any negative findings, thereby improving client care and outcome.

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