SARASOTA MEMORIAL HOSPITAL

NURSING PROCEDURE

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<th>TITLE: WOUND DEBRIDEMENT</th>
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**RESponsibility:**

*Credentialed RN (Center Wound Healing)*  
Certified Wound Care Nurse

**Purpose:**

To safely and effectively remove non-viable tissue by instrument/sharp debridement for the purpose of providing a clean wound bed.

**Knowledge Base:**

1. *Only credentialed RNs in the Center for Wound Healing or a Certified Wound Care Nurse may perform this procedure after successfully completing a wound debridement course.*

2. A physician order/referral is required prior to performing sharp debridement.

**Equipment:**

1. Instrument Set.
2. Scalpel and blade.
3. Scissors: small fine serrated and large with or without serration.
4. Forceps: Adson—with or without teeth/Adson-Brown “toothed” forceps.
5. Clamp: Kelly, Mosquito type.
7. Disposable drape.
8. Normal Saline.
11. Wound covering.
13. Tape.

**Procedure:**

1. Identify and assess patient and wound.

2. Determine blood flow by touch/Doppler.

3. Photograph wound (optional). Refer to SMH Policy 01.PAT.28 Photographing/Videotaping/Audio Recording Patients.

4. Verify physician orders/referral. A consent must be signed prior to the procedure.
5. Explain debridement procedure carefully, and answer any questions.

6. Determine if pain medication is needed.
   a. **Topical**—Lidocaine spray or solution, Lidocaine solution or gel.
   b. **Oral/IV/IM**—as a pre-operative/pre-debridement regimen, approximately thirty (30) minutes prior to procedure. Increases patient tolerance/compliance.

7. Prepare sterile field and equipment.

8. Don gloves.

9. Remove existing wound covering and discard.

10. Cleanse area with saline/wound cleanser.

11. Using the pick-up forceps, lift the non-viable tissue or eschar you are trying to debride, and cut it with scalpel or scissors. Cut it with care, and try to take it down in layers to prevent removal of viable tissue.
   a. Pain and bleeding are signs of viable tissue
   b. Two (2) types of bleeding to fear
      1) Bleeding you can’t see the source of
      2) Bleeding you can hear
   c. Methods to stop bleeding
      1) Pressure: simple, effective, always with you—ten (10) minutes
      2) Silver Nitrate sticks—minor bleeding
      3) Topical agents—Thrombin, Gelfoam, Surgicel, and Fibrin glue
      4) Battery ophthalmic cautery.

12. Remove as much non-viable tissue as possible.
   a. Aggressiveness of debridement.
      1) Depends largely on amount of devitalized tissue.
      2) Patient pain tolerance limits.
   b. Set time schedule and limits
   c. 15-30 minutes per session.
   d. Serial sessions.
      1) Limits patient/clinician fatigue.
      2) Limits bleeding.
      3) Limits patient discomfort.
13. Stop debriding:
   a. Impending exposure of tendon or bone.
   b. Location of fascial plane.
   c. Location of a named structure.
   d. As necessary, based on professional judgment and experience.

14. Request re-evaluation from physician when:
   a. Patient febrile or decreased performance status.
   b. No wound improvement over several weeks/sessions.
   c. Cellulitis.
   d. Gross purulence/infection.
   e. Impending exposed bone or tendon.
   f. Abscessed area.
   g. Major vessel encountered.
   h. “Holes”.
   i. Extensively undermined ulcers or wounds

15. Post debridement care.
   a. Cleanse the wound with saline/water.
   b. Apply appropriate dressing for location/wound.
   c. Use of antibiotics varies with patient.

DOCUMENTATION:

Narrative Notes: Record the date and time of the debridement, wound condition, any problems that occurred, patient tolerance, and type of wound dressing applied.

REFERENCE:


REVIEWING AUTHOR(S)

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