Louisiana State Board of Nursing

DECLARATORY STATEMENT SCOPE OF PRACTICE FOR REGISTERED NURSES - WOUND CARE MANAGEMENT

Registered nurses render care that is directed towards the prevention and treatment of wounds. Wounds are a common health care challenge that often occur with or result from chronic disorders such as impaired circulation and malnutrition. Nursing care of skin/wound conditions involves the identification, assessment, management, and on-going evaluation of patients with alterations in skin/tissue integrity, that includes but is not limited to draining wounds, pressure ulcers, and vascular ulcers, and conditions resulting from incontinence, surgical procedures, and/or trauma.

In accord with LRS 37:913(14)(l) and LAC 46:XLVII.3703. registered nurses may perform additional activities beyond those taught in basic nursing education programs. Enterostomal Therapy (ET) Wound Ostomy Continence (WOC) nursing is a specialized area of nursing practice that focuses on skin care, wound management and management of incontinence that includes prevention, health maintenance, therapeutic, and rehabilitation interventions. The WOC(ET) nurse and the certified wound care nurse (CWCN) are recognized as an expert in skin care and wound management and through the standards developed by national organizations collaborates and shares this specialized knowledge with other health care professionals. Wound management requires the skills of the interdisciplinary team that includes the physician, WOC(ET)/CWCN and other registered nurses, dietitian, physical therapist, occupational therapist, social workers, and orthotist.

Professional organizations, such as the National Pressure Ulcer Advisory Panel Consensus Development Conference, the Wound Ostomy and Continence Nurses Society (formerly International Association of Enterostomal Therapy), and the Agency for Health Care Policy and Research (AHCPR) agree upon the following definitions and clinical presentations of the four stages of pressure ulcers:

Stage I: Nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue 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 muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts may be associated with Stage IV pressure ulcers.

Definitions:

Pressure ulcer means any lesion caused by unrelieved pressure resulting in damage of underlying tissue (AHCPR, 1994).

Wound means a disruption of normal anatomic structure and function resulting from pathologic processes beginning internally or externally (Lazarus, Cooper, Knighton, Margolis, Pecoraro, Roachcaner, & Robson, 1994).

Scope of Practice - The Louisiana State Board of Nursing recognizes that assessment, planning, intervention, teaching, evaluation, and supervision are the major responsibilities of the registered nurse in the practice setting. The registered nurse is responsible for performing a nursing assessment and physical examination for preventative and restorative nursing and for providing patient/family teaching. Recognizing that the physician must always prescribe wound care, the following roles are defined to delineate the scope of practice for each member of the nursing team members.

WOC(ET)/CWCN assumes the role of the wound care nursing specialist in a variety of health care settings to include the staging of the wounds and wound care management that includes appropriate selection of preventive and therapeutic devices, wound care products, and the frequency of intervention when so directed by an authorized prescriber.

The registered nurse initiates appropriate wound preventative measures, stages wounds and collaborates with the wound care team in the implementation and evaluation of nursing interventions as prescribed by an authorized prescriber.

Delegation - In accord with the Law Governing the Practice of Nursing (RS 37:913(14) the registered nurse may delegate select nursing interventions to qualified nursing personnel as set forth in the Board's rules on delegation (LAC 46:XLVII.3703.). The registered nurse retains the accountability for the total nursing care of the individual.

The registered nurse may delegate to a licensed practical nurse wound care interventions in any situation when the registered nurse has deemed the patients status is stable, the intervention is based on a relatively fixed and limited body of scientific knowledge, can be performed by following a defined nursing procedure with minimal alteration, responses of the individual to the nursing care are predictable and changes in the patient's clinical condition are predictable. Furthermore, the patient's medical and nursing orders are not subject to continuous change or complex modification, appropriate RN supervision is available, and provided that the LPN has been adequately trained and demonstrates competency in the performance of the specific nursing intervention and this said training and competence is documented in the LPN's file.

The parameters as set forth in the Board's rules on delegation govern which wound care interventions the RN may delegate to the LPN in any given situation. For example, the RN may delegate to an LPN the wound care of a stable patient with a healing stage III wound, when the patient's response to care is predictable and all other criteria are met.

However, if a patient three days after abdominal surgery develops fever, tenderness around the incision, and purulent drainage from the wound, the patient's status is unstable, the patient's response to wound care interventions are not predictable, and the RN may not delegate wound care to the LPN.

Contingent upon the RN's evaluation of each patient's condition and also upon the RN's evaluation of competency of each unlicensed assistive personnel (UAP), an RN may delegate non-complex tasks to a UAP. A non-complex task is one that can safely be performed according to exact directions, with no need to alter the standard procedure, and the results are predictable. When the above criteria has been met, the following wound care interventions may be delegated when non-complex: topical application of anti-infective medications, protective ointments, wound cleansers, skin sealants, gauze, transparent films, hydrocolloids, and hydrogels and the cleansing of the skin of a mature, healed PEG tube site with soap and water or 3% hydrogen peroxide. For example, the application of a transparent film to an area of redness over a bony prominence in a stable patient is a non-complex task; however, the application of a transparent film and hydrocolloid agent for the purpose of autolytic debridement of the wound is a complex task and may not be delegated to UAP. The Board recognizes the responsible of the employing agency to have written policies and procedures to allow for such delegable interventions, and a written system in place to document competency for each caregiver.

Wound care management requires the registered nurse to collaborate with other members of the interdisciplinary team to ensure that the individual's nutritional and psychosocial needs are being met and to provide for preventive and therapeutic measures. The registered nurse should consult with the physician and/or WOC(ET)/CWCN to assure safe, quality nursing measures that facilitate appropriate skin and wound management.

References:

Louisiana State Board of Nursing's rules §3701. & §3703.

Lazarus, G., Cooper, D., Knighton, D., Margolis, D., Recoraro, R., Robson, M. (1994). Definitions and guidelines for guidelines for assessment of wounds and evacuation of healing. Archives of Dermatology, 130(4), 489-493.

United States Department of Health and Human Services (USDHHS). (1994). Treatment of Pressure Ulcers. (Publication No.95-0652). Rockville, MD: Public Health Service, Agency for Health Care Policy and Research.

Wound, Ostomy and Continence Nurses Society. (1997). Position Statement: Role of Wound, Ostomy and Continence (ET) Nurse/Wound Care Nursing Specialist. Laguna Beach, CA.

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