Developed by the British Columbia Provincial Nursing Skin & Wound Committee in collaboration with NSWOCs/WCs from:

First Nations Health Authority Health through wellness | fraserhealth Better health. Best in health care. | Interior Health | island health | northern health the northern way of caring | Provincial Health Services Authority Province-wide solutions. Better health. | Vancouver CoastalHealth Promoting wellness. Ensuring care | Providence Health Care | Yukon

Procedure: NPWT Open Wound Dressing Application – Prevena Plus 125

Endorsement **British Columbia & Yukon**	• Endorsement done: N/A • Endorsement pending: FNHA, FHA, IHA ISLH, NHA, PHSA, VCH/PHC & Yukon; until endorsement has been granted by your health authority (HA), please follow your HA's current document.
DST Indications for Use	This Negative Pressure Wound Therapy (NPWT) dressing procedure is used with the **disposable** 3M/KCI Prevena Plus therapy unit and in conjunction with the Negative Pressure Wound Therapy: Guideline.

Practice Level
British Columbia & Yukon
	• British Columbia: order to carry out NPWT, Registered Nurses, Registered Psychiatric Nurses and Licenced Practical Nurses, in accordance with the British Columbia College of Nurses and Midwifes' scope of practice for their specific designation, must:
	  ○ Have HA and/or agency policy in place to support their designation in providing NPWT.
	  ○ Have a HA approved NPWT decision support guideline.
	  ○ Successfully complete the additional education for monitoring/managing the NPWT system.
	  ○ Successfully complete additional education for NPWT dressing application.
	  ○ Have client specific NPWT orders from a Physician/NP/NSWOC/Wound Clinician.
	  ○ For LPNs, follow an established NPWT wound treatment plan.
	• Yukon: Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses refer to organizational policy and practice in accordance with regulatory bodies.
	• Clients undergoing NPWT require an interprofessional approach to provide comprehensive, evidence-based assessment and treatment.

Background	Prevena Plus 125 NPWT system:
	• Is a disposable, single-use 14-day system which delivers a Pressure Therapy of 125mmHg with a Therapy Setting of Continuous; comes with rechargeable batteries and a power cord..
	• Has a disposable 150 mL canister to be used for wounds with anticipated small to moderate exudate, for anticipated larger amounts, choose an alternative NPWT device.
	• For open wounds, to be used with NPWT granufoam and if needed, woven PHMB gauze or ribbon packing, as wound fillers. Meshed non-adherent contact layers can be used as interfaces to protector fragile structures, (e.g., tendon). The dressing is changed a minimum of three (x 3) times weekly.
	• For disposal, the device and batteries should be recycled as electrical or electronic equipment.
	General Safety Considerations for all NPWT Medical Devices
	• Defibrillation: when defibrillation is required in the area of the NPWT dressing, remove the dressing or place the paddles in an alternate position; ensure that the NPWT device is at least 2 meters away from the paddles.
	• Electrodes or Conductive Gel: do not place EKG or other electrodes/conductive gels in contact with the NPWT dressing/device.
	• Magnetic Resonance Imaging (MRI) environment:
	  ○ The NPWT device itself **cannot** go into the MRI environment. If a canister is present, disconnect it from the device and ensure that all tubing clamps are open to allow any exudate to flow into the canister.
	  ○ If the NPWT dressing (interface and/or foam) does not contain silver, then the dressing may remain in place. If the MRI is to be done in the area of the wound, consult Radiology Department regarding the need to remove the dressing.

	○ If the NPWT dressing is comprised of a silver-based interface or Granufoam Silver foam or is a Prevena dressing, consult with the MRI Radiology Department; depending upon the MRI magnetic field environment, the silver-based dressing may need to be removed. • Diagnostic Imaging: Silver-based interfaces, Granufoam Silver foam or Prevena dressings may impair visualization with certain imaging modalities; consult with the Radiology Department regarding the need to remove the dressing. • Hyperbaric Oxygen Chamber environment: the NPWT dressing should be removed and a different type of dressing used for the duration of the HBO treatment period. • Cell phones or similar products could affect the NPWT device; move the NPWT device away 2 meters (6.5 feet) away from the device if interference is suspected. • Do not connect NPWT dressings to wall suction.
Bookmarks	Equipment and Supplies Procedure: Applying / Reapplying NPWT Dressing Procedure: Removing the NPWT Dressing Procedure: Changing the Canister Managing Prevena Plus 125 Alerts / Alarms Client Showering Transition/Discharge Planning Client/Family Education and Resources Documentation Bibliography/References Document Creation
Related Documents	Guideline: Negative Pressure Wound Therapy Guideline: Wound Management Procedure: Wound Cleansing Procedure: Wound Packing Additional Education Requirements/Competencies: NPWT Monitoring/Managing E-Learning Module: NPWT Monitoring/Managing Additional Education Requirements/Competencies: • NPWT Dressing Application Learning Plan • NPWT Dressing Application Competencies E-Learning Module: NPWT Dressing Application Open Wound Documentation Tool: NPWT Safety/Monitor Check Flow Sheet Client Health Education Resource (CHER): NPWT Prevena Plus 125 CHN Service in progress

Equipment and Supplies

NPWT Supplies

- NPWT Dressing Kit (Granufoam or Simplace) small, medium, large, X-large, TRAC Pad, polyurethane acrylic transparent film drape, paper ruler, documentation sticker and tubing cap.
  - Note: if there is a concern with skin sensitivity due to polyurethane or the location of the wound makes it difficult to position of a polyurethane film then use Dermatac, a silicone-acrylic transparent film drape which can be reposition (available either in a dressing kit or drape only).
- Prevena Plus 125 device with 3 rechargeable AA batteries and a power cord.
- 150mL Prevena Plus 125 canister.

Dressing Change Supplies

- Personal protective equipment (i.e., safety glasses, gloves, gown, and mask as required).
- Major dressing tray.
- Sterile normal saline at least 100 mL, at least at room temperature.
- Sterile scissors.
- Sterile gloves - 1 pair.
- Clean gloves - 2 pair.
- Foam tip measuring probe or metal probe or cotton tipped applicator.
- Alcohol swab(s).

- Procedure pad(s).
- Skin film barrier wipe.
- Camera.
- Pen or felt marker.

Pre-Soak Supplies (for wounds only)

- 50-60 mL syringe – syringe type is depended upon Pre-Soak Method #1 or #2 (see pg. 8)
- Sterile normal saline at least at room temperature.
- Clean gloves - 1 pair.
- 1 sterile 4 x 4 dressing (to keep the NPWT canister tubing end sterile, if caps not available).
- Sterile scissors.
- Alcohol swab(s).
- Procedure pad(s).
- Lidocaine 1% (without epinephrine), if ordered.

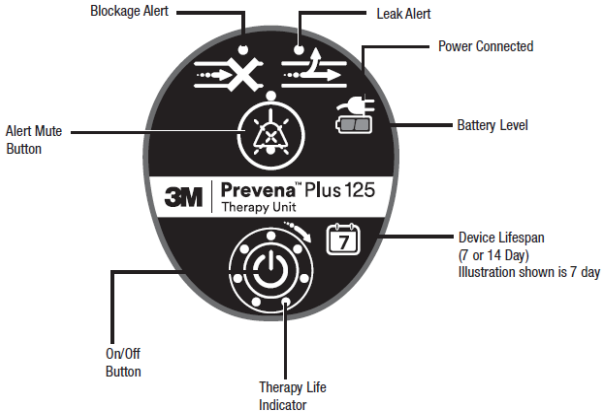
Additional Supplies as per the Pre-Printed Order (PPO) or in the written care plan.

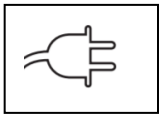
- Sterile PHMB woven gauze roll or ribbon packing.
- Meshed non-adherent contact layer.
- Sterile hydrocolloid or extra transparent film drape.
- Adhesive remover.
- Non-sterile ostomy strips, rings, paste, if needed for filling in folds and creases.

Applying / Reapplying a NPWT Granufoam Dressing with a Prevena Plus 125 Device **Click here for Removing a NPWT Granufoam Dressing with a Prevena Plus 125 Device**	
Steps	**Key Points**
1. Review the Orders: • Read the NPWT order and overall care plan. • Review allergies/sensitivities to acrylic adhesives/products.	The transparent drape has an acrylic adhesive coating, which may present a risk of an adverse reaction in client who are allergic or hypersensitive.
2. Prepare the client: • Explain the procedure to client/family keeping in mind the concepts of Trauma Informed Practice and, where appropriate for the client, Indigenous Cultural Safety, and obtain verbal consent (if possible). • Assess client's pain/anxiety, if needed provide medication(s) as ordered and allow time for the medication(s) to take effect. • Position the client for the procedure.	The client undergoing NPWT may experience pain and anxiety. Provide pain management strategies, medications, education, reassurance and position for comfort.
3. Set-up for the procedure: • Gather the supplies. • Perform hand hygiene; put on clean gloves. • Set up the sterile dressing tray; designate one side of the sterile field for cutting the wound fillers/interface layers. • Add the supplies needed for peri-skin protection and any additional wound fillers. • Place pen or felt marker outside the sterile field. • Remove the current dressing. • Remove gloves; perform hand hygiene and don clean gloves.	Perform hand hygiene to avoid contamination. Add all sterile supplies to sterile field. If using ostomy rings, please note these are not sterile and should added to the perimeter or edge of the sterile field.
4. Clip peri-wound/surrounding skin hair, if needed: • Using scissors or clippers, clip the hair in the area where the dressing is to be applied. Clip as close to the skin surface as possible. • Avoid shaving whenever possible.	Hair can make it difficult to achieve an airtight seal and may cause pain during drape removal. Shaving is not recommended as this can cause skin irritation and may lead to folliculitis but, if needed, then shave in the direction of the hair follicles.

Steps	Key Points
5. Cleanse and assess: • Use a 15 cm foam tipped applicator, metal probe or sterile cotton tip applicator to explore the depth & direction of undermining, sinus tracts/tunnels. • Cleanse the wound and peri-skin with at least 100 mL of NS. Use moistened gauze and forceps to remove loose slough/debris. • Complete a full wound assessment. • If taking photos for documentation, remove gloves, perform hand hygiene, take photos & then put on clean gloves. If this is a dressing reapplication, determine the appropriateness of ongoing NPWT; if there are any concerns, e.g. wound/graft deterioration, notify the Physician/NP/NSWOC/WC	If the undermining, sinus tract/tunnel end cannot be probed (is beyond 15cm), do not irrigate or pack these areas. Cleansing the wound aids in removal of exudate and promotes visualization of wound bed tissues. Cleansing the wound bed and peri-skin ensures all loose hairs is removed and not retained in the wound Measurements taken provide an objective assessment of wound healing. Measurements must be compared to previous measurements to ensure that wound healing is occurring, if this is the goal.
6. Prepare the peri-skin and surrounding skin: • Use sterile forceps to apply skin barrier wipe to the peri-skin and surrounding skin, let dry. • Use non-sterile ostomy strips, rings, paste to fill in any skin folds and creases. If needed, the following may be done now or done later once the transition to sterile gloves is complete: • Window-pane the wound or graft with a hydro-colloid barrier (up to 5cm).	Barrier film wipe protects the skin from adhesives, helps to maintain an airtight seal and may extend the wear time of the dressing. Ostomy rings, paste, or strips aid in levelling the peri-skin and supports an airtight seal. If the client/wound situation requires sterile technique for all aspects of the dressing then prepare the peri-skin once sterile gloves are donned; otherwise, can be done with clean gloves once the wound and surrounding area is cleansed.
7. Transition to sterile technique: • Remove clean gloves; perform hand hygiene. • Open the NPWT dressing supplies and place on the sterile field. • Place Prevena Plus 125 device and canister on a clean work surface • Perform hand hygiene. Apply sterile gloves for the remainder of the procedure.	Instruments used to clean the wound are no longer sterile and therefore not used to fill the wound bed.
8. Prepare the peri-skin and surrounding skin if not already prepared (Step 6).	
9. Prepare the interface layer(s), if being used: • Cut the layer to fit into the wound area requiring protection.	The interface layer must be meshed and can be either a non-antimicrobial, (i.e., silicone) or antimicrobial, (i.e., silver). White foam may also be used to protect areas of concern, (i.e., tendon).
10. Prepare the necessary wound filler(s): • Black foam: cut to fit the visible wound space. For smaller wounds, ensure that the black foam piece is cut greater than the TRAC pad size. • White foam: cut the foam piece(s) to fit the undermining/sinus tract ensuring the foam piece is narrower at one end and/or cut to fit the wound space. • PHMB gauze roll or ribbon: cut to length.	When cutting the wound filler(s) cut over the sterile field and ensure loose particles of foam/gauze are not retained in the wound bed.
11. Fill/pack wound dead space: • Start with the undermining/sinus tract and use one of the following:	

Steps	Key Points
○ PHMB gauze/ribbon: lightly fill/pack the area, ensure to leave a 1 to 2 cm tail of packing visible. If using PHMB gauze roll, fold in the gauze edges to keep the raw edges off the wound bed. ○ White foam: Lightly pack the narrow end of the foam in the space until it reaches the end of the sinus track. Pull back by 1 to 2 cm to ensure that the foam end is visible in the wound cavity. • If using, line the wound bed with an interface layer: ○ Lay down a non-adherent contact (meshed) layer or white foam. • Then fill/pack the wound cavity using one or a combination of the following: ○ White foam. ○ Black/silver foam: Ensure the foam size is cut larger than the TRAC pad.	Fill/pack the undermined or sinus tract to support granulation but do not over-pack as packing he space too tightly will cause pressure on the new tissue. White foam is recommended for use in undermining/ sinus tracts as it is denser and will not break when removed. White foam is always cut wider at the end that rests in the wound cavity and is cut narrower at the end that is placed in the undermining/sinus track. The white foam/gauze must be visible in the wound bed and to ensure it is removed when the dressing is changed. Where possible, place the manufactured edge of the foam face-down on the wound bed. White foam must always be covered with black foam to support proper removal of exudate. Ensure the foam top layers cut larger than the TRAC pad to prevent Medical Device-Related Pressure Injuries.
12. Ensure the fill/pack is complete: • If more than one piece of foam/gauze is used ensure that all foam and gauze edges are in contact with each other. Wound fillers may need to be overlapped. • Ensure the black foam is the final (top) layer as the TRAC pad must sit on the black foam: ○ If the wound is smaller than the TRAC pad, ensure the top layer is black foam is cut larger than the TRAC pad and the peri-skin protected. Ensure the black foam is 2.5 cm higher than the peri- skin level.	The entire wound surface must be covered with wound filler(s) and all pieces must be in contact with each other to maintain suction and the flow of exudate. Foam touching the peri-skin will cause skin irritation, maceration or ulceration. The TRAC pad must sit on the black foam to ensure proper removal of exudate. Filling to this height ensures the TRAC pad is resting at skin level when vacuum is applied and not below the skin surface.
13. Apply the NPWT transparent film drape: • The transparent drape may be cut into strips to make it easier to handle; cut the drape before removing the backing layer. •Remove the back Layer #1 and lay (do not stretch) the drape over the foam and 3 to 5 cm of prepped or window-paned peri-skin. • Gently press the transparent drape onto the skin to ensure an airtight seal. • Remove the top Layer #2 from the transparent drape. Remove the blue strip/tabs. • Repeat these steps as needed. • When using more than one piece of NPWT transparent film drape, ensure that the edges overlap to prevent air leakage.	Ensure transparent drape does not cover body orifices, stomas, or drain openings. Applying stretched film drape can lead to blistering over the peri-skin. Adding a small border of additional drape may extend the dressing wear time. Remaining transparent film drape pieces may be used to patch any air leaks, if necessary.
14. Apply the SensaTRAC pad: • With sterile gloves, determine the best position for the SensaTRAC pad and tubing; do this in	The positioning of the TRAC pad and tubing must avoid boney prominences and skin folds; positioning

Steps	Key Points
consultation with the client, if possible. • Cut at least a 2.5 cm round opening in the transparent film drape over the foam. • Remove SensaTRAC pad layers #1 and #2. • Place SensaTRAC pad directly over the cut opening in the drape. Gently press and smooth out pad to ensure an airtight seal. • Pull back on the blue tab to remove the clear stabilization layer. • Secure the pad tubing to the dressing with strip(s) of transparent drape.	should allow for client comfort and ease of doing ADLs. Wound exudate passes from the wound through the foam into the TRAC pad/tubing. **If the drape opening is cut is too small (i.e., with an 'X' or a 'slit') the drape opening will close causing a blockage alarm.**.
15. Prepare the canister: • Hold canister and device, one in each hand. Slide the bottom of canister into slot on the bottom of the device. • Close the canister into the device; upper locking tab will click when canister is secure. • Connect SensaTRAC pad tubing to the connector tubing. • Connect connector tubing to the canister's tubing ports found on the side of the canister. • Ensure the tubing clamp is open.	For wounds with large exudate, the dressing may be connected to VACUlta4 or ActiVAC device and the Pressure and the Therapy Settings can be set as needed to manage the wound (see Procedure: NPWT Reusable Dressing Application - VACUlta4 or ActiVAC).
16. Start the therapy: • Turn the device ON by holding the ON/OFF button for 3 seconds All seven **green** 'Therapy Life Indicator Lights' will light up. ◦ The Prevena Plus 125 Therapy device is pre-set with a Pressure Setting of 125 mmHg and a Therapy Setting of Continuous.	
17. Assess for an airtight seal: • With an airtight seal the dressing will collapse and have a wrinkled appearance, be firm to the touch and no hissing sounds heard. • If this is not the case, gently press down all dressing areas and apply additional transparent film drape to achieve a seal. • If the TRAC pad needs to be repositioned on the dressing, perform hand hygiene and apply sterile gloves, then: ◦ Trim out the existing TRAC pad. Cleanse with alcohol swab prior, if needed. ◦ Seal the original hole with drape. ◦ Wipe drape with alcohol swab (30+ seconds) and let dry prior to making a new 2.5 cm opening. • Then reapply the TRAC pad and secure in place using strips of sterile drape.	If the dressing does not collapse in less than 1 minute, there may be a dressing leak or tubing blockage. **Note**: The vacuum effect of Prevena Plus 125 device is slower than the reusable devices. Repositioning is often done to aid in positioning and performance of activities of living. Where possible do in consultation with the client. .

Steps	Key Points
18. Clean up workspace: • Discard the dressing tray and disposable scissors. • Remove gloves; perform hand hygiene.	
19. Document on the dressing: • Apply the documentation sticker (if available) to the transparent drape. • Document the number of interface(s) and wound filler(s) on the dressing. The following coding system may be used, if helpful: ○ I for Interfaces. ○ G for Gauze. ○ W for White Foam. ○ B for Black Foam. ○ S for Silver Foam. • Write the date on the canister.	If documentation sticker not available, then write the count on the dressing itself or on a piece of tape and apply to the dressing. Document the number of wound filler pieces after each dressing change. It is critical to ensure that all pieces are removed at the next dressing change.
20. Conduct the first Safety/Monitoring Check: • Check the system from the dressing to the power source. • Assess that the battery is charging. Ensure device is plugged in. • Ensure tubing is secure to minimize the risk of a fall. • Assess colour, movement, warmth, sensation distal to the dressing if NPWT on a limb.	The power symbol will turn from **yellow** to **green** when fully charged.  Carrying case is available for ambulating clients to enhance safety.

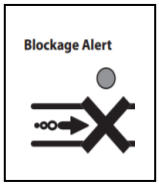
Removing a NPWT Prevena Dressing	
Steps	**Key Points**
1. Review the chart: • Read NPWT orders and overall care plan. • Review the documented packing count.	
2. Prepare the client: • Explain the procedure to client/family keeping in mind the concepts of Trauma Informed Practice and, where appropriate for the client, Indigenous Cultural Safety, and obtain verbal consent (if possible). • Assess client's pain/anxiety, if needed provide medication(s) as ordered and allow time for the medication(s) to take effect. • Position the client for the procedure.	The client undergoing NPWT may experience pain and anxiety. Provide pain management strategies, medications, and reassurance.
3. Set-up for dressing removal: • Turn off the NPWT device and clamp the dressing tubing for at least 30 minutes prior to dressing removal. • If needed, do a NS pre-soak **or** a pre-soak with Lidocaine 1% (without epinephrine) with, or followed by, the same amount of NS using one of the following pre-soak methods:	Black or silver foams are more likely to adhere to the wound bed than white foam. Turning the NPWT device off releases the suction, allowing wound exudate to collect on the wound bed which helps to release the foam.

Steps	Key Points
Pre-soak Method #1: ○ Prepare a 50-60 mL Luer-lock syringe with the solution. ○ Disconnect the dressing and canister tubing, keeping ends sterile with 4x4 gauze. ○ Cleanse the connection with an alcohol swab and let dry 30+ seconds. ○ Connect the syringe to the dressing tubing. ○ Slowly instill the solution into the dressing; the dressing should budge slightly. If this does not occur, add more plain NS. ○ Remove the syringe and reconnect the dressing tubing to the canister tubing. ○ Let the solution rest in the dressing for at least 20 to 30 minutes. Pre-soak Method #2: ○ Prepare a 50-60mL catheter tip or Toomey syringe with the solution. ○ Cleanse tubing 5 cm away from the dressing. Use an alcohol swab and let dry for 30+ seconds. ○ Cut the cleansed TRAC pad tubing and connect the syringe to the dressing tubing.	Use of Lidocaine 1% without epinephrine requires a Physician/NP order, see the document bookmark Lidocaine: Physician/NP Prescribing in the Negative Pressure Wound Therapy: Guideline for dosage. The pre-soak method, either #1, #2, or another method, is to be determined through consultation with Physician/NP/NSWOC/ Wound Clinician.
4. Prepare for the procedure: • Gather supplies. • Position client for the procedure. • Clamp both tubing clamps. • Disconnect dressing and canister tubing. • If canister is to be reused, protect the dressing tubing end using the protective cap, if available. If not, use sterile gauze dressing. • Perform hand hygiene; put on clean gloves. • Set up a sterile dressing tray with NS.	See Equipment and Supplies List.
5. Review packing count on the dressing: • Check the NPWT dressing for the current number of wound filler and interface layers/pieces used with the previous dressing change; ensure that this count matched the packing count documented in the client's chart.	Counts of the interface layer(s) and wound filler(s) should match.
6. Remove the dressing: • Anchor the drape with one hand; with the other hand, gently lift the dressing horizontally away from the wound, and slowly push the skin away from the dressing. If drape not releasing use an adhesive remover. • Gently lift off the dressing. • Count all the packing pieces to ensure all are removed. If the count does not match, inform Physician/NP. • Remove gloves; perform hand hygiene.	A peeling motion can cause epidermal stripping and irritates the peri-skin and surrounding skin. Retained packing pieces can increase the risk of wound infection. Report any packing miscounts in the Patient Safety Learning Reporting system.
7. If changing the dressing within the 14-day life of the device then see Applying/Reapply a Dressing Procedure and connect the dressing to the existing	

Steps	Key Points
device. If device has come to its 14-day end-date or the NPWT has been discontinued, dress the wound as per orders.	 Recycle batteries where possible; the device should be recycled as electrical/electronic equipment.

Changing the Prevena Plus 125 Canister

The solid **yellow** light over the Blockage Alert icon comes on when the canister is full or if there is a blockage. There is also an escalating audible beeping alarm which repeats every 15 seconds.

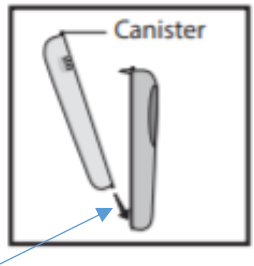


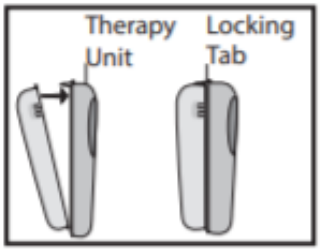
To mute the alarm, press the Alert Mute button for 3 seconds. The alarm will be muted for 2 minutes. Alarm will repeat until canister is changed. Press the Alert Mute button again, if needed.

When the canister is changed, the audible and visual alarms will turn off.

Steps

- Gather supplies:
  - New sterile canister (150 ml)
  - Alcohol swab x1
  - Clean gloves
- Perform hand hygiene and don gloves.
- Press/hold ON/OFF button 3 seconds to turn the therapy OFF.
- Slide tubing clamp close to where the tubing plugs into the canister. Close the clamp.
- Unplug the tubing from the canister tubing ports.
- Remove device from carrying case, if using.
- Press upper Locking Tab on canister to remove canister.
- Hold canister and device, one in each hand. Slide the bottom of canister into slot on the bottom of the device.
- Close the canister into the device; upper Locking Tab will click when canister is secure.
- Date the canister.
- Return device to carrying case, if using.
- Cleanse canister tubing port site with the alcohol swab for 30+ seconds.
- Dry for 30+ seconds. Reattach dressing tubing to the canister ports.
- Press/hold ON/OFF button 3 seconds to turn the therapy ON.





Managing Prevena Plus 125 Alerts / Alarms

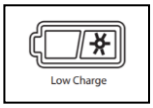
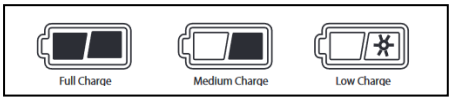
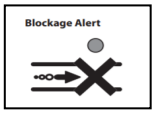
Prevena Plus 125 Therapy is ON and working correctly when there is at least one of the seven Therapy Life Indicator **green** lights visible.

- Once the therapy is on for one continuous hour, the 14-day lifespan of the device begins. It continues the count down even if the therapy is off.
- Each **green** light indicates one day of remaining therapy. Following each day of therapy, a green light turns off.

Alarms

The alarms sound two beeps that repeating every 15 seconds, except for the Low Battery Indicator, which beeps every 4 minutes. The alarm repeats until the condition is corrected.

The alarm can be muted, for 2-minute intervals, by pressing and holding the Alert Mute button for 3 seconds. Repeat if needed.

Managing Prevena Plus 125 Alerts / Alarms continued	
Alerts / Alarms Display	**Monitor / Manage**
Therapy is near completion/completed: • When there is 8 hours left of therapy, the last Therapy Life Indicator will show both **green** and **yellow** light. • When the therapy is completed, only the **yellow** light is showing. The device will sound 8 beeps, followed by a continuous beep for 5 seconds, then turn off. 	• Closely monitor the therapy as it nears completion.
Low battery indicator: • Solid **yellow** light with 2 beeps which repeats every 4 minutes. 	• Alarm indicates approximately 2 hours of therapy remain; plug device in immediately to avoid disrupting the therapy.  • If the three AA batteries do not re-charge, then change them.
Blockage / Canister Full alarm: • Solid **yellow** light with 2 beeps which repeats every 15 seconds. 	• To clear a blockage, ensure the tubing clamp is open and that the tubing is not kinked. • If canister is full, change canister.
Leak alarm: • Solid **yellow** light with 2 beeps which repeats every 15 seconds. 	• Check for small lifts on the edge of the dressing and drape; add strips of transparent drape as needed. • Ensure tubing connection is tight. • Press/hold ON/OFF button 3 seconds to restart the therapy. If the air leak is resolved, the **green** light will stay on. If not, the alarm will sound; try again to seal the air leak.
System default alarm: • All lights turn on and flash. • Two beeps will sound, repeating every 15 seconds. 	• Press/hold ON/OFF button 3 seconds to see if the device will turn ON. • If device does not turn on, a new device is needed. If new device not available within 2 hours, remove the dressing and apply the alternate dressing • Notify the Community Health Unit of the situation.
3M/KCI Customer Service 1-800-668-5403	

Client Showering
The client may shower but tub bathing should wait until after NPWT has been discontinued. When showering: • Ensure the device, which runs on batteries, is outside of the shower spray area, (e.g. put it just outside the shower, hang it on the soap/shampoo holder). • Try to keep the shower spray off the dressing as much as possible. Should soap or shampoo come in contact with the dressing, lightly rinse it off with an indirect spray of the shower. • When finished, lightly pat dry the dressing including the surrounding area. Do not rub as rubbing may lift the edges of the dressing.

Transition/Discharge Planning Refer to Negative Pressure Wound Therapy: Guideline for the following:
- For transition between an acute site to another acute care site
- For transition between an acute care site to community care
- For transition between an acute care site to long-term care
- For transition between a community care site or a long-term care site to an acute care site

Client/Family Education and Resources

1. Acute Care:
   - When NPWT is started, inform the patient/family of the rationale for and the underlying principles of NPWT as well as general information regarding the Prevena device.
   - Prior to transition of care to Community (home/Ambulatory Care Clinic):
     - Review the Client Health Education Resource: NPWT Prevena 125 Plus CHN Services which outlines the frequently asked NPWT-related questions and specific Pevena device details e.g. the management of alerts/alarms, changing the canister.
     - Identify which method the patient is to use to manage an irreparable dressing leak and put together the client's Troubleshooting Supplies bag.
2. Community Care:
   - When the client is transitioned from Acute Care with NPWT in place or when the NPWT is started at home/ambulatory clinic, inform/re-inform the client/family of the rationale and underlying principles of NPWT. Also review the frequently asked NPWT-related questions and specific information regarding the Prevena device being used, (e.g., how to manage the alerts/alarms, change the canister) see Client Health Education Resource: NPWT Pevena 125 Plus CHN Services.
     - Review/identify the method that the client is to use to manage an irreparable dressing leak. Ensure client has a Troubleshooting Supplies bag.
3. Long Term Care:
   - When the resident/person-in-care is received back from Acute Care with NPWT in place or when NPWT is started within the long-term care site, inform the resident/person-in-care and their family of the rationale for and the underlying principles of NPWT as well as general information regarding the Prevena device being used.

Documentation

1. With each dressing change, document on the appropriate paper or electronic documentation tool, as per agency policy, and include the following:
   - The full wound assessment.
   - The numbers (#) of interface and wound filler packing pieces removed and replaced.
   - Document the client's response to the dressing change.
2. Document NPWT clinical outcomes and care plan revisions as they occur.
3. For Acute Care & Long Term Care, document safety/monitoring checks on the NPWT Safety/Monitoring Check Flow Sheet.
4. For Acute Care & Long-Term Care, document canister fluid volume; use the Fluid Balance (In/Out) flow sheets as per unit policy.
5. Document client/family teaching provided on transition of care and any Troubleshooting Supplies given to client/family on transition to the community setting.
6. When a NPWT Prevena dressing is applied/changed in the Operating Room (OR), the following is documented in the OR record:
   - NPWT type: Open Wound, Closed Incision or Skin Graft.
   - Type(s) of pieces (black foam, white foam, interfaces) placed in or removed from the wound cavity by the surgical team.
   - Number of pieces placed in/removed from the wound cavity by the surgical team.
7. Report NPWT adverse events in the Patient Safely Learning System or report the safety event according to Health Authority or agency guidelines.

Bibliography/References

1. Refer to the Negative Pressure Wound Therapy Guideline for the master list of references.
2. 3M 2023. *Prevena Plus 125 Instructions for Use - For Clinicians Only*.

Document Creation

This guideline is based on the best information available at the time it was published and relies on evidence and avoids opinion-based statements where possible. It was developed by the Provincial Nursing Skin & Wound Committee and has undergone provincial stakeholder review.

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