



Rancho Los Amigos National Rehabilitation Center

OUTPATIENT SERVICES: MOBILE CLINIC

POLICY AND PROCEDURE

SUBJECT: Wound Care: Incision and Drainage Procedure

Policy No.: 400
Supersedes: New
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1. **PURPOSE:**

- 1.1 To provide guidance and describe the process in performing incision & drainage procedure in the mobile clinic according to DHS – LA County Standard of Care.

2. **POLICY:**

- 2.1 Medical Provider performs incision & drainage procedure with the assistance of RN or LVN.
2.2 The CMA can help set up the procedure and clean up after.
2.3 Discussion of the procedure with the patient will be documented in the patient’s medical records.

3. **DEFINITION:**

Incision and Drainage also known as clinical lancing is a common clinical procedure in which a linear incision is created to the abscess in order to decompress to help release the pus and pressure built up under the skin. The procedure is done to relieve pain and speeds up healing in which a conventional treatment like antibiotics is not working.

4. **INDICATIONS:**

- 4.1 Large abscess (>5 mm)
4.2 Palpable, fluctuant abscess
4.3 An abscess that does not resolve despite conservative measures.

5. **EQUIPMENT:**

- 5.1 I & D Tray – (contains all the needed supplies to perform an incision & drainage procedure)
5.2 Iodoform Packing Strips ¼ inches.
5.3 Local Anesthetic – Lidocaine 1% or 2%
5.4 Sterile gloves
5.5 Anti-infective solution – Bexachorophene (pHisoHex), Chlorhexidine Gluconate (Hibiclens), Providine-Iodine (Betadine).
5.6 Sterile surgical scalpel with holder size 11.
5.7 Gauze Bandage Rolls – Kerlix, Coban, or Tubular Stretch Bandage.
5.8 Personal Protective Equipment (gown, face shield, goggles, et. al).

6. **PATIENT PREPARATION:**

EFFECTIVE DATE: 3/1/22

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

APPROVED BY:

Ben Davis

- 6.1 Explain and answer all patient questions before the incision and drainage procedure.
- 6.2 Obtain a signed consent before the procedure.
- 6.3 Place the patient on the position to help optimize and facilitate the procedure.

7. LOCAL ANESTHESIA

- 7.1 Use 27-gauge needle or smaller.
- 7.2 Inject slowly.
- 7.3 Inject directly into the dermis through open wound (not through intact skin).

8. WOUND PREPARATION

- 8.1 Inspect for any foreign bodies, deep tissue layer damage, and injury to nerve, vessel, or tendon.

9. CLEANING

- 9.1 Irrigate with normal saline with at least 200ml.
- 9.2 Bexachorophene (pHisoHex), chlorhexidine gluconate (Hibiclens), Povidone-Iodine (Betadine) should not be used inside wounds but may be applied to external, intact skin desire.

10. TECHNIQUE AND IMPLEMENTATION:

- 10.1 Gather and prepare the necessary equipment and supplies and provide privacy.
- 10.2 Perform hand hygiene. Put on gloves and as needed, other personal protective equipment to comply with standard precautions.
- 10.3 Perform ultrasonography with a portable device, if needed, to better assess the abscess site.
- 10.4 Remove and discard your gloves and repeat hand hygiene.
- 10.5 Position the patient appropriately to gain access to the abscess site.
- 10.6 Place a fluid-impermeable pad under the patient to absorb drainage.
- 10.7 Place a basin below the wound so that the irrigation fluid flows from the wound into the basin and drains from the clean to the dirty end of the wound.
- 10.8 Put on a gown and a mask with a face shield or a mask and goggles, as needed, to comply with standard precautions. Perform hand hygiene and don sterile gloves.
- 10.9 Clean the affected area with a facility-approved antiseptic agent and allow it to dry.
- 10.10 Place a sterile drape around the affected area.
- 10.11 Administer a local anesthetic until adequate anesthesia is obtained.
- 10.12 After achieving adequate anesthesia, collect an anaerobic culture (if needed) by using a needle and syringe to aspirate an anaerobic specimen from the abscess site.
- 10.13 An anaerobic culture may be necessary if the patient is immunocompromised or has a history of IV drug abuse.
- 10.14 Pick up the #11 scalpel blade using the scalpel holder and incise skin.
- 10.15 Make a simple linear incision through the total length of the abscess, following the natural folds of the skin to allow pus to drain under its own pressure.
- 10.16 If a patient requires a fluid culture, gram stain, and susceptibility to identify the causative organism obtain a culture by swabbing the purulent fluid in the abscess with a culture swab and then placing the swab in a culture tube.
- 10.17 This may include patients who will receive antibiotics after the procedure and who have one of the following: a severe, local infection, systemic signs of infection, history of recurrent or multiple abscesses, failure of initial antibiotic treatment, are young infants or elderly, or are

immunocompromised.

- 10.18 Probe the abscess cavity using a hemostat to break up loculations, identify foreign bodies and ensure proper drainage.
- 10.19 Don't probe the wound with a gloved finger or scalpel because a sharp foreign body can injure a gloved finger and a scalpel can cause tissue damage.
- 10.20 Keep in mind that probing the wound can cause pain, so the patient may require additional anesthetic.
- 10.21 Using a commercial irrigation device or a syringe attached to an angiocath, irrigate the abscess cavity copiously with sterile normal saline solution until you've removed all visible pus.
- 10.22 Discard the syringes and scalpel in a puncture-resistant sharps container to prevent sharps-related injuries.
- 10.23 Dry intact skin with a sterile gauze pad. For a previously healthy patient with an abscess less than 2" (5 cm), leave the wound open to allow healing by secondary intention.
- 10.24 For a patient who is immunocompromised or has diabetes, a pilonidal abscess, or an abscess greater than 5 cm, pack the wound cavity with wound packing material (such as sterile gauze, iodoform gauze, or silver-containing hydro fiber); avoid packing the cavity too tightly because excessive pressure can cause tissue necrosis. If needed, leave a tail of packing material about $\frac{3}{8}$ " (1 cm) long to wick drainage from the site. Cover the wound with a sterile absorbent dressing.
- 10.25 If you obtained a culture specimen, label it in the presence of the patient to prevent mislabeling. Then place the specimen in a laboratory biohazard transport bag and immediately send it to the laboratory with the appropriate laboratory request form (if necessary).
- 10.26 Note that anaerobic specimens may be transported in the syringe or in an anaerobic transport container. Discard used supplies in appropriate receptacles.
- 10.27 Remove and discard your gloves and other personal protective equipment. Perform hand hygiene.

11. **TETANUS VACCINATION:**

11.1 Some wounds raise the risk of tetanus infection. If needed, a tetanus vaccination may be given for prophylaxis.

12. **SIGNS OF COMPLICATIONS:**

12.1 Complications of incision and drainage are rare. Inadequate drainage can result in local extension of the abscess, which can lead to such conditions as osteomyelitis, septic thrombophlebitis, fasciitis, and fistula formation. Aggressive drainage can damage adjacent structures and lead to bacteremia.

13. **WOUND CARE TEACHINGS/INSTRUCTIONS:**

- 13.1 Patient Teaching Instruct the patient (or caregiver, if applicable) to seek medical attention if the patient develops a fever; chills; increased pain, tenderness, redness, or swelling; or pus reaccumulating in the area.
- 13.2 Have the patient return for another follow-up visit in 24 to 48 hours. Change the packing every 24 to 48 hours as long as purulent drainage persists.
- 13.3 If drainage has stopped by the time the patient returns for a follow-up appointment, remove the

old packing and instruct the patient to begin warm, wet soaks several times per day until healing occurs.

13.4 Teach the patient and family about pain management strategies, include information about the patient's pain management plan and adverse effects of pain treatment.

14. **POSSIBLE ANTIBIOTIC PROPHYLAXIS SITUATIONS OR WHEN TO CONSIDER ANTIBIOTIC:**

14.1 **Coexisting Conditions**

- 14.1.1 Diabetes mellitus
- 14.1.2 Peripheral vascular disease
- 14.1.3 Elderly
- 14.1.4 Immunocompromised
- 14.1.5 Previous radiation to the site
- 14.1.6 Malnutrition (e.g., alcoholism, chemotherapy)
- 14.1.7 History of previous infection or slow healing
- 14.1.8 Chronic steroid use
- 14.1.9 Obesity

14.2 **Locations**

- 14.2.1 Increased bacteria
- 14.2.2 Axilla, mouth, anogenital areas
- 14.2.3 End-arterial locations (fingers, toes) with diseases of vascular compromise
- 14.2.4 Over joint spaces where there is a possibility of entering joint (e.g., metacarpophalangeal joints)

14.3 **Contamination**

- 14.3.1 Dirty wounds, especially those sustained at farms, meatpacking plants, etc.
- 14.3.2 Less than optimal sterile technique (should be rare).
- 14.3.3 Deep puncture wounds
- 14.3.4 Bites (especially human and cat bites)
- 14.3.5 Presence of a retained foreign body

14.4 **Method of Wound Injury**

- 14.4.1 Crush injury (10-fold increase in infection) with devitalized skin.
- 14.4.2 Penetrating injury

REFERENCE:

1. Lippincott (2021, May 21). *Incision and Drainage of an Abscess (Advanced practice), Ambulatory Care*. Retrieved November 23, 2021, from <https://procedures.lww.com/lmp/view.do?pId=6761051&hits=drainage,incision,incise&a=false&ad=false&q=incision%20and%20drainage%20procedure>