

Review of Actions Identified in Clinical Vignette for G0465

Action	Action Completed for First Wound?	Same Action Completed Again for Each Additional Wound?
Pre-Service		
Review patient chart	Yes	No
Review prior wound care notes	Yes	Yes
Review recent laboratory results (including platelet count and coagulation studies, as indicated)	Yes	No
Obtain a detailed interval history (with attention to new diagnoses, medication changes, and recent hospitalizations)	Yes	No
Examine wound for size, depth, tissue quality, drainage, and evidence of infection	Yes	Yes
Assess systemic and local factors affecting wound healing	Yes	Yes
Review risks, benefits, and alternatives	Yes	Yes
Obtain informed consent for procedure	Yes	Yes (if new wound, or wound not previously consented to)
Position patient	Yes	Yes (depending on location of wound)
Remove existing dressing	Yes	Yes
Clean wound	Yes	Yes
Document baseline wound measurements and staging	Yes	Yes
Determine venous access plan and perform venipuncture (taking into account comorbidities that may complicate phlebotomy)	Yes (time should be added to account for larger wounds or more than one wound).	No
Request additional support (if necessary)	Yes	No
Intra-Service		
Perform focused pre-procedural vascular and infection reassessment	Yes	Yes

Action	Action Completed for First Wound?	Same Action Completed Again for Each Additional Wound?
(including non-invasive imaging to verify adequacy of perfusion)		
Document baseline tissue characteristics, perfusion and any features concerning for infection	Yes	Yes
Obtain a venous blood sample (drawn into specialized tubes)	Yes	Yes (if another kit is needed)
Process venous blood sample in a closed system using a validated centrifugation protocol to concentrate platelets (or other specific steps, as provided by the manufacturer)	Yes	Yes (if another kit is needed)
Isolate and activate blood-derived product (as indicated by the instructions for use)	Yes	Yes
Prepare the wound bed	Yes	Yes
Utilize anesthesia (as necessary)	Yes	Yes
Perform sharp or selective debridement down to viable, bleeding tissue	Yes	Yes
Remove biofilm and necrotic debris	Yes	Yes
Irrigation	Yes	Yes
Homeostasis	Yes	Yes
Debride posterior heel ulcer bed	Yes	Yes
Excise nonviable skin and subcutaneous tissue (if present) and tendon/muscle tissues to level of viable tissue	Yes	Yes
Repeat wound imaging to capture perfusion changes, assess residual infection risk, and provide visual confirmation of a viable wound bed	Yes	Yes

Action	Action Completed for First Wound?	Same Action Completed Again for Each Additional Wound?
Prepare wound bed to optimize wound surface for positioning of blood-derived product	Yes	Yes
Re-measure wound and stage/classify (e.g., Wagner/Wiffl)	Yes	Yes
Document findings with calibrated planimetry and digital photography	Yes	Yes
Post Service		
Ensure secure placement of final dressing	Yes	Yes
Complete documentation	Yes	Yes
Perform customized offloading with a total contact cast	Yes	Yes
Provide patient-specific discharge instructions, including wound care at home, pain management, and reinforcement of the importance of systemic disease control in wound healing	Yes	No
Assess psychosocial and logistical barriers to adherence (e.g., caregiver support or transportation needs)	Yes	No
Arrange home health or visiting nurse services (if appropriate)	Yes	No
Document encounter in medical record, update progress notes	Yes	No
Schedule patient's next follow-up visit	Yes	No
Communicate with primary care provider or referring provider (if needed)	Yes	No