Wound Care Protocol Handout

The diagnostic process

- Understand and manage the underlying disease processes – cardiovascular, dermatologic, genitourinary, metabolic, malignancies, etc
- Accurately determine the wound etiology – include both extrinsic and intrinsic contributory factors , as well as, the current state of the wound
- Diagnostic findings are key for planning local wound management and disease/impairment management.

Common Risk factors

- Unrelieved pressure, poor perfusion
- Incontinence
- Limited mobility and inadequate positioning
- Inadequate/poor nutrition
- Immune compromised state
- Advanced disease state
- Chronic diseases: diabetes, CVI, rheumatoid , and respiratory diseases

Patient History and Examination

- Past Medical History
- Wound history (current and prior wounds)
- Medications
- Mobility and ADL status
- Hygiene
- Cognition/capacity for new learning
- Vascular status
- Pain and sensation
- Nutritional Status (albumin level, vitamins)
- Support systems (family and community resources)
- Presence of pressure or trauma
- Tobacco or alcohol use

WOUND EXAMINATION/DOCUMENTATION

- Type of wound
- Location of wound
- Wound measurement (L x W x D)
- Shape

- Presence of necrotic tissue, slough
- Odor
- Exudate (amount, quality – description)
- Stage – if pressure ulcer (unable with eschar)
- Periwound tissue
- Presence of infection
- Percent of granulation tissue

Types of Wounds

1. Venous Ulcers
    - Liposclerosis
    - Red base of skin
    - Irregular wound margins
    - Shallow crater
    - Moderate to heavy exudates
    - Pain
    - Edema
    - Typically found on the medial side of lower leg and ankle
2. Arterial Ulcers
    - PAD: symptoms usually progress from intermittent claudation to night pain, followed by rest pain
    - Diabetes
    - Advanced age
    - Anatomical location: between toes, tips of toes, around lateral malleolus
    - Thin shiny skin
    - Hair loss
    - Pallor upon elevation
    - Deep pale wound bed
    - Regular margins
    - Minimal exudates
3. Pressure Ulcers – any lesion caused by unrelieved pressure resulting In damage (necrosis) of underlying tissue. Sheer and May be contributing factors. Usually located over Bony prominences and are **staged** to classify Degree of tissue damage involved.

- Shape is regular and appears as the underlying bony prominence (unless sheer is an issue)
- Localized edema
- Minimal to moderate exudates initially
- Only wounds that are staged
- Do not reverse the stage
- Back of formulary has a guide
- Variable wound bed color, if clean, pink/red
- Variable amount of necrotic tissue
- Unstageable if covered in slough or eschar
- Variable depth and presence/absence of tunneling and undermining
- Deep tissue injury presents as red, or ecchymosis

Stages

Stage I --- Non-blanchable erythema of intact skin. 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. Presents 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. Presents as a deep crater with or without undermining.

Stage IV ---Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (tendon, joint capsule, etc). Undermining and sinus tracts (tunnels) may also be present.

Good Wound Care Basics

- Wound bed preparation: irrigation, good cleaning, include periwound skin
- If packing: document type, amount/length and/or number used
- Packing is to **loosely** fill the void, if packed tightly – will decrease the blood flow through capillaries
- Moisture balance adding/absorbing

When choosing a dressing --- use Hospice Wound Dressing Selection Guide

***** Any other products need to be approved by a clinical manager*****

Wounds need to be visualized by the hospice nurse each visit – if unable need to document why

Wounds need to be measured once a week

The Leaders in Home Health and Hospice Care

Merrimack Valley Hospice Wound Dressing Selection Guide

Description	Eschar* (Colors may vary)	Predominantly Slough (Infection may be present)	Granulating/ Mixed Wound Tissue	Fibrin (Appears yellow)	Granulating and/or Epithelializing	Skin Tear	Epithelializing	Healed Wounds, Skin at Risk or Closed Surgical Incisions
= indication of exudate level Exudate Level	Moderate to None	High ← → to Moderate			Moderate ← → to Scant			None
Depth	Unknown	Deep	Deep/Shallow	Deep/Shallow	Deep/Shallow	Shallow	Shallow	Closed
Treatment Objective	Debride*	Cleanse, Debride, Absorb, Fill Dead Space			Protect, Hydrate, Fill Dead Space			Protect
NOTE: STABLE ESCHAR ON HEEL SHOULD NOT BE REMOVED . STABLE IS DEFINED AS NO EDEMA, ERYTHEMA, OR DRAINAGE.	**Non-Stageable** **<u>Dry:</u>** DCD only (change PRN) **<u>Draining:</u>** Normlgel & DCD (change q.o.d.) or Mesalt&DCD (daily)	**Stage III or IV with drainage and odor** Melgisorb & mepilex border (change 2-3x/wk) or Actisorb (change1-2x/wk) With ABD cover drsg	**Stage III or IV with drainage** Melgisorb with either a 4x4 DCD or ABD pad (change 1-3x/wk)	**Stage III or IV** Mepilex border (change 1-3x/wk)	**Minimal exudate Partial-full thickness Stg II or III** Mepilex border (change 1-3x/wk) or Comfeel (change 1-3x/wk)	**Partial-Full Thickness Stg II or III 1st choice** normlgel & DCD (change 3x/wk) **2nd choice** Mepilex border (change 1-2 x /wk)	**NOTE:** IF WOUND BED IS DRY ADD MOISTURE, IF EXCESS DRAINAGE-ABSORB.	**Intact/stg I** Calmoseptine or A&D ointment