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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| STAGE IA reddened area that will NOT blanch when pressure is applied. This is known as non-blanchable erythema, redness does not fade when digital compression is applied and then removed. The color range is from red to dusky cyanosis. The pressure area is irregular and ill-defined and reflects the shape of the object which created the pressure, or the bony prominence underlying the skin.ACTIONS KEY POINTS

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| Cleanse wound with wound cleanser. | Removes gross contaminants from pressure area. |
| Pat dry around the reddened area with gauze. | Drying allows adhesive to adhere to skin. |
| Apply hydrocolloid or foam dressing. | Provides protection against friction and pressure. |
| Leave undisturbed for 5 to 7 days or until nursing practice dictates otherwise. | N/A |
| Repeat Steps 1-4 until reddened area is gone. | N/A |
| Change position of resident every two (2) hours or more often according to need. | Initiate facility’s turning and positioning and mobility program are essential in reducing risk of Pressure Sores. |
| Identify and use pressure relieving devices, i.e., special mattresses, boots, chair pads, etc. | Reduces incidence of severity of Pressure Sores. |
| Dietician is to complete a nutritional assessment upon identification and every month thereafter. | Maintaining adequate intake of protein and calories is of primary importance. |
| Provided Range of Motion as needed. | Active and passive R.O.M. promotes activity and reduces effects of pressure on tissue. |
| Keep family and resident informed and very involved in decisions, care planning, etc. | Encourage resident family in decision process and informed of progress/lack of progress. |

Additional Interventions-Stage I Pressure Sore:* Notify physician for treatment orders
* Notify family/responsible party
* Update the plan of care to reflect new problem and interventions
* Wound care team to assess weekly and document progress
* Lab values reviewed by physician and dietician-baseline lab; CBC, pre-albumin, serum albumin, FBS, BUN, and electrolytes.

Note: Failure to demonstrate progress in healing within 2-4 weeks calls for reassessment regarding the adequacy of the overall treatment plan and the need for modification of treatment plan.  |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| **PRACTICE GUIDELINES: STAGE II**Partial thickness skin loss involving the epidermis and/or dermis. This stage is an extension of the acute inflammatory extension of the acute inflammatory response leading to fibroblastic response in all layers. The pressure sore is shallow and surrounded by a broad, indistinct area of heat.ACTIONS KEY POINTS

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| Cleanse wound with wound cleanser. | Removes gross contaminants from wound. |
| Pat the area around the wound dry with gauze. | Drying allows adhesive to adhere to skin. |
| Apply hydrocolloid or transparent dressing.  | N/A |
| Change dressing PRN. Also be aware of Medicare Allowable. | N/A |
| Repeat Steps 1-4 | N/A |
| Change position of resident every two (2) hours or more often according to the need. | Initiating facility’s turning and positioning and mobility programs are essential in reducing risk of Pressure Sores. |
| Identify and use pressure relieving devices i.e., special mattresses, boots, chair pads, etc. | Reduces incidence and severity of Pressure Sores. |
| Dietician is to complete a nutritional assessment upon identification and every month thereafter. | Identify factors compromising intake and offer support with eating-consider nutritional supplements. |
| Provide Range of Motion as needed. | Promotes activity and reduces effects of pressure on tissue. May consider – therapy. |
| Keep family and resident informed and very involved in decision, care, planning, etc. | Encourage resident and family participation in decision process and informed of progress-lack of progress. |

Additional Interventions- Stage II Pressure Sore:* Notify physician for treatment orders.
* Notify family/responsible party
* Update the plan of care to reflect new problems and interventions.
* Wound Care Team to assess weekly and document progress
* Lab values reviewed by physician and dietician-baseline lab; CBC, pre-albumin, serum, albumin, FBS, BUN and electrolytes.
* Nutritional Support

NOTE: Failure to demonstrate progress in healing within 10 days calls for reassessment regarding the adequacy of the overall treatment plan and the need for modification of treatment plan. |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| **PRACTICE GUIDELINES: STAGE III**\*\*\*\*\* NOTE: Wounds with Eschar cannot be staged!\*\*\*\*\*Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. A distinct ulcer margin is formed as the epidermis thickens and rolls over the edge toward the ulcer base. There is intensive reactive fibrosism, inflammation, and retraction in the dermis and subcutaneous fat. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. ACTIONS KEY POINTS

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| --- | --- |
| Cleanse wound with wound cleanser. | Removes gross contaminants from wound bed without toxicity. |
| Pat dry around the wound with gauze. | Drying allows adhesive to adhere to skin. |
| Apply calcium alginate dressing or pack wound filler into the wound cavity, undermining or other tissue voids (Do not pack to tightly). | Calcium alginate manages and absorbs excess wound fluid. Maintains moist environment. |
| For moderate Draining Wounds: Apply hydrocolloid over calcium alginate as secondary dressing. This may be changed three (3) times per week unless drainage is striking through the secondary dressing more frequently. If so, this must be documented in the resident’s chart. | Provides insulation and additional absorbency. Also protects wound from contaminants and maintains moist environment. |
| For Heavy Draining Wounds: Apply foam as a secondary dressing. This may be changed daily (every 24 hours) if drainage is striking through the secondary dressing. If not, the dressings should be changed every other day. Documentation of amount of drainage is critical. | The optimal temperature for healing wounds is 98.6 degrees. Each time a dressing is changed, the optimal temperature for healing the wound is reduced, and it takes the body several hours to return the wound site to that optimal healing temperature; thus, it may prolong the healing process if wounds with only moderate drainage are changed daily.  |
| For Non-Draining Wounds: Apply Hydrogel wound filler or Hydrogel dressing and cover with transparent dressing three times per week. | N/A |
| Change position of resident every two (2) hours or more often according to need. | Immobility and inactivity are associated with developing larger ulcers. Initiating the facility’s turning and positioning and mobility programs are essential in reducing risk of pressure sores. |
| Identify and use pressure-relieving devices, i.e., special mattresses, boots, chair pads, etc. | Redistributes pressure. Helps reduce severity of ulcer. |
| Dietician to complete nutritional assessment with appropriate recommendations. | Includes accurate ongoing monitoring of fluids and nutritional intake and lab values. |
| Provide Range of Motion as needed. | Active and passive ROM promotes activity and reduces effects of pressure on tissue. May consider physiotherapy. |
| Keep family and resident informed and very involved in decisions, care planning, etc. | Encourage resident and family participation in decision process and informed on progress/lack of progress.  |

  \*\*\*\*\*\*\*\*\*ELMINATE NECROTIC TISSUE PER PHYSICIAN’S ORDER\*\*\*\*\*\*\*\* |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| ADDITIONAL INTERVENTIONS:* Notify physician for treatment orders.
* Notify family/responsible party.
* Update the Plan of Care to reflect new problem and interventions.
* Wound care team to assess weekly and document progress.
* Lab values reviewed by physician and dietician-baseline lab; CBC, pre-albumin, serum albumin, FBS, BUN, and electrolytes.
* Nutritional Support: Vit C, 500 mg, po BID, Zinc Sulfate, 220 mg po qd. Arginaid.
* Assess for pain related to the pressure sore during turning, treatments/dressing changes and debridement.
* Provide analgesia as needed and appropriate.

NOTE: Failure to demonstrate progress in healing within 10 days calls for reassessment regarding the adequacy of the overall treatment plan and the need for modification of treatment plan.  |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| **PRACTICE GUIDELINES: STAGE IV**\*\*\*\*\*\*\*\*\*WOUNDS WITH ESCHAR CANNOT BE STAGED\*\*\*\*\*\*\*\*\*Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle and supporting structures such as tendon, joint capsule, and bone. The skin surrounding the pressure sore is erthematous, warm and indurated. The size of the ulcerated area may be deceiving with a small lesion opening to a much larger necrotic area beneath. (Undermining and sinus tracts-tunneling) ACTIONS KEY POINTS

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| Cleanse wound with wound cleanser. | Removes gross contaminants from wound bed without toxicity. |
| Allow area around wound to air dry or pat dry with gauze. | Drying allows adhesive to adhere to skin. |
| Apply calcium alginate dressing or pack calcium alginate wound filler into wound cavity, undermining or other tissue voids. (Do Not pack too tightly). | Calcium alginate manages and absorbs excess wound fluid and maintains moist environment. |
| For Moderate Draining Wounds: Apply hydrocolloid over calcium alginate as a secondary dressing. This may be changed three (3) times per week unless drainage is striking through the secondary dressing more frequently. If so, this must be documented in the resident’s chart. | Provides insulation and additional absorbency. Also protects wound from contaminants and maintains moist environment. |
| For Heavy Draining Wounds: Apply foam as a secondary dressing. This may be changed daily (every 24 hours) if drainage is striking through the secondary dressing. If not, the dressings should be changed every other day. Documentation of amount of drainage is critical. | See 4 & 5 above. |
| For Non-Draining Wounds: Apply Hydrogel wound filler or Hydrogel dressing and cover with transparent dressing three times per week. | N/A |
| Repeat Steps 1-5 until wound drainage lessens. | N/A |
| If calcium alginate wound filler dries on the wound do not pull off. First, saturate the dressing with wound cleanser to re-gel or re-hydrate the dressing. Gently remove the calcium alginate. | N/A |
| Changing position of resident every two (2) hours or more often according to need. | Initiating the facility’s turning and positioning and mobility programs are essential in reducing risk of pressure sores. |
| Identify and use pressure-relieving devices, i.e., special mattresses, boots, chair pads, etc. | Reduces incidence and severity of pressure sores. |
| Dietician to complete nutritional assessment with appropriate recommendations and documentation. | Active and Passive ROM promotes activity and reduces effects of pressure on tissue. |
| Provide Range of Motion as indicated. | Active and Passive ROM promotes activity and reduces effects of pressure on tissue. |
| Keep family and resident informed and very involved in decisions, care planning, etc. | Encourage resident and family participation in decision process and informed or progress/lack of progress.  |

\*\*\*\*\*ELIMINATE NECTOTIC TISSUE PER PHYSICIAN’S ORDER\*\*\*\*\* |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| Additional Interventions:* Notify physician for treatment orders.
* Notify family/responsible party
* Update the plan of care to reflect new problem and interventions.
* Wound care team to assess weekly and document progress.
* Lab values reviewed by physician-baseline lab; CBC, pre-albumin, serum albumin, FBS, BUN, and electrolytes,
* Nutritional Support: Vit C, 500 mg, po BID, Zinc Sulfate, 220 mg po qd., Arginaid.
* Assess for pain related to the pressure sore during turning, treatments/dressing changes and debridement.
* Provide analgesia as needed and appropriate.

NOTE: Failure to demonstrate progress in healing within 10 days calls for reassessment regarding the adequacy of the overall treatment plan and the need for modification of treatment plan.  |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| SKIN CARE/WOUND MANAGEMENT PROTOCOLSRECOMMENDED AVOIDANCESAVOIDANCE KEY POINTS

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| Do Not rub reddened skin | Increases injury to skin |
| Heat lamps | Dries sores. (goal is to keep moist) |
| Blow dryers | Dries sores (goal is to keep moist) |
| Under pads | Decreased effectiveness of actual pressure relief devices |
| Sheepskin | Provides no pressure relief |
| Donuts | Provides no pressure relief |
| Incontinent briefs | Provides no pressure relief |
| Providine Iodine (i.e., Betadine) | Studies have identified these items to be ineffective when treating pressure sores. |
| Sugar, glycerine | See above |
| Antacids | See above |
| Honey | See above |
| Tropical vitamins, minerals | See above |
| Cornstarch | See above |
| Vaseline | See above |
| Hydrogen peroxide | See above |
| Chlorhexidine gluconate (i.e., Hibiclens) | See above |
| Dakins solution | See above |
| Wet to dry gauze | Traumatic to wound bed upon removal |

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| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

|  |  |
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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| SUBJECT: Debridement MethodsPRACTICE GUIDELINES: Wounds with necrotic or dead tissue must be debrided in order to optimize the speed of healing. (In fact, in order for a wound to qualify for third party reimbursement, it must first be debrided.) Wounds that have been debrided generally heal about twice as fast.There are four basic types of debridement methods recognized by HCFA. These four methods are:1. Surgical: This type of debridement is generally considered to be the last resort of debriding a wound. It requires the use of a scalpel or other sharp instrument. Surgical debridement is performed by a physician and involves cutting of dead or necrotic tissue from a wound. It may also involve the removal of necrotic tissue surrounding the wound.
2. Mechanical: This involves the removal of necrotic tissue, slough, or other impediments to wound healing by means of scrubbing, scraping, otherwise manually removing dead tissue. An example is scrubbing the wound with a 4x4 to remove eschar. Using wet to dry gauze and then pulling the dead tissue with the dry gauze is also considered mechanical debridement. Mechanical debridement is generally more desirable than surgical, though it too can be very painful for the resident.
3. Chemical: Chemical debridement involves the removal of dead tissue by means of applying an enzymatic agent to the necrotic tissue. Chemical debridement is generally less painful than the two alternatives above. However, care should be taken when using enzymatic agents, as they can also dissolve viable tissue. Santyl is safe and does not harm viable tissue. This is the only debride currently recommended.
4. Autolytical: Autolytic debridement is by far the most desirable means of debridement, as it involves very little pain for the resident, requires less nursing time, and is by far the easiest means of debridement. Autolytic debridement is simply allowing the body to debride the necrotic tissue on its own. Generally, it is very important to use a dressing which promotes moist wound healing. Moist wound healing provides the ideal environment for autolytic debridement by:
5. Insulating the wound and keeping it at 98.6 decrees (F), which is optimum healing temperature.
6. Bathing the wound in fluid filled with phagocytes, which eat way necrotic tissue and keeps the wound clean.
7. Keeping the nerve ending bathed in fluid to minimize pain. Certain wound dressings provide a moist environment and allow the body to debride the wound without surgical, mechanical, or chemical means. These dressing should be left in place for as long as possible (up to 7 days) to ensure quick and completed debridement.
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| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| PRACTICE GUIDELINESTYPE: Skin Tears, Abrasions, LacerationsACTIONS INTERVENTIONS

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| Assess wound. Provide emergency care if needed. | Assess reason for wound (if other than surgical). |
| Contact physician. | Assure proper handling and transfer techniques were used. Retrain as needed. |
| Cleanse area with normal saline (unless specified otherwise by physician. | Assess need for protective clothing, i.e., long pants, geri-gloves, geri-legs, etc. |
| Treat area per physician’s orders, i.e., use of topical antibiotics, Steri-strips, if needed, cover with hydrocolloid or transparent dressing (change per manufactures recommendation). | Observe environment for need of protective equipment, i.e., padding for wheel chair arms, legs, side rails, etc. |
| Document  | Document for tracking a report for Quality Assessment and Assurance Committee. |
| Write descriptive initial note. |  |
| Write weekly progress note until healed. |  |

TYPE: Perineal Excoriations ACTIONS INTERVENTIONS

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| Cleanse with soap and water. Pat dry. DO NOT RUB. | Strive to keep resident clean and dry. |
| Apply moisturizing lotion or skin conditioning cream. | Monitor progress on Bowel and/or Bladder, or Incontinent Management Program. |
| Apply moisture barrier. | Complete steps 1-3 under actions with each incontinent episode. |
| Assess reason for incontinence. |  |
| Determine if candidate for B & B Program for incontinence Management Program. |  |
| Explain reasons, actions and interventions to the resident. |  |
| Chart all of the above. |  |

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| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| TYPE: RashesACTIONS INTERVENTIONS

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| Assess resident. | If allergy determined, stop use of product(s) responsible. |
| Notify physicians. | Check resident’s nails and clip if needed. |
| Cleanse area with soap and water. Pat dry DO NOT RUB. | Check resident frequently to determine need for further topical or po treatment. |
| Follow physician’s orders for po’s (orals) and/or topical. | Comfort resident as much as possible. |
| Explain physician’s findings, orders, treatment, etc. to the resident. | Assess need for analgesics. |
| If allergy determined, note in all appropriate areas of clinical record. |  |
| Chart all of the above. |  |

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| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| TYPE: Venous Leg UlcersMost leg ulcers are caused by venous insufficiency. Some of the characteristics of venous ulcers that differentiate them from other leg ulcers are:1. Irregular shape
2. Swelling or edema-generalized.
3. Brown or red pigmentation on the perimeter of the ulcer.
4. Pain relief when leg is elevated.
5. Shallow wound with diffuse edges.
6. Normal pulses.

SPECIAL NOTE: It is very important to have a proper diagnosis for the healing of a leg ulcer. If a leg ulcer’s etiology is not venous insufficiency (i.e., arterial or diabetic), compression is contraindicated. DO NOT use compression on these wounds.ACTIONS KEY POINTS

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| Cleanse wound with wound cleanser. | Remove gross contaminants from wound bed. |
| Allow area around wound to air dry or pat dry with gauze. | Drying allows adhesive to adhere to skin. |
| Apply foam dressing without adhesive border to the ulcer. | Foam dressing without adhesive border allows for faster healing. |
| Wrap the lower leg with hydrocolloid dressing according to package insert instructions. | This wrap provides sustained compression necessary to heal venous ulcers by compensating for venous insufficiency.  |
| Leave undisturbed fluid strikes through the secondary dressing. | Leaving undisturbed allows for better healing and is less traumatic to wound. |
| Repeat Steps 1-5 until ulcer is healed. | Self-explanatory. |
| Note: If the wound is exceptionally dry or exceptionally wet it may be important to use a dressing other than a foam dressing without adhesive border such as calcium alginate wound dressing if drainage is very high or hydro-gel wound filler if the wound is dry. | If wet wound: Alginate will manage and absorb excess fluid. If dry wound: hydro-gel wound fluid will donate needed water. |

 Venous ulcers require both moist wound healing and sustained compression to heal. Compression provides compensation for insufficient blood pressure to properly move blood from the calf to upper body. For this reason, a moist wound dressing and a sustained compression bandage are recommended. |
| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| TYPE: Arterial or Diabetic Leg Ulcers Arterial and/or diabetic ulcers have very different characteristics than venous leg ulcers. They are characterized by:1. Even, “punched out”, smooth wound margins
2. Frequently necrotic
3. Pain increased during elevation of leg
4. Distal location (over bony prominence of leg)
5. Thin, shiny, dry skin
6. Thickened toenails
7. Diminished or absent pulse.

**SPECIAL NOTE: Compression is contraindicated for arterial or diabetic ulcers. Also, remember that elevation of leg may increase pain.** ACTIONS KEY POINTS

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| Cleanse wound with wound cleanser. | Removes gross contaminants from wound bed without toxicity. |
| Allow area around wound to air dry or pat dry with gauze. | Drying allows adhesive to adhere to skin. |
| Apply calcium alginate dressing or pack calcium wound filler into the wound cavity, undermining or other tissue voids. (Do Not pact too tightly.) | Calcium alginate manages and absorbs excess wound fluid and maintains moist environment. |
| For Moderate Draining Wounds: Apply hydrocolloid over calcium alginate as a secondary dressing. This may be changed three (3) times per week unless drainage is striking through the secondary dressing or more frequently. If so, this must be documented in the resident’s chart. | Provides insulation and additional absorbency. Also protects wound from contaminants and maintains moist environment. The optimal temperature for healing wounds is 98.6 degrees. Each time a dressing is changed, the optimal temperature for healing the wound is reduced, and it takes the body several hours to return the wound site to that optimal healing temperature; thus, it may prolong the healing process if wounds with only moderate drainage are changed daily. |
| For Heavy Draining Wounds: Apply foam as a secondary dressing. This may be changed daily (every 24 hours) if drainage is striking through the secondary dressing. If not, the dressing should be changed every other day. Documentation of amount of drainage is critical. | SEE ABOVE. |

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| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| TYPE: Arterial or Diabetic Leg Ulcers, continuedACTIONS KEY POINTS

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| For Non-Draining Wounds: Apply Hydro-gel wound filler or Hydro-gel dressing and cover with transparent dressing three times per week. | N/A |
| Repeat steps 1-5 until wound draining lessens. | N/A |
| If calcium alginate wound filler dries on the wound, do not pull off. First saturate the dressing with wound cleanser to re-gel or re-hydrate the dressing. Gently remove the calcium alginate. | N/A |
| Change position of resident every two (2) hours or more often according to need. | Initiate the facility’s turning and positioning and mobility programs are essential in reducing risk of pressure sores. |
| Identify and use pressure-relieving devices, i.e., special mattresses, boots, chair pads, etc. | Reduces incidence and severity of pressure sores. |
| Dietician to complete nutritional assessment with appropriate recommendations and documentation. | Includes review and on-going monitoring of fluid and Nutritional intake and lab value. |
| Provide Range of Motion as indicated. | Active and Passive ROM promotes activity and reduces effects on pressure on tissue and may assist with circulation. |
| Keep family and resident informed and very involved in decisions, care planning, etc. | Encourage resident/family participation in decision process and informed progress or lack of. |

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| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |

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| SUBJECT: CLINICAL STANDARDS OF PRACTICE “SKIN & WOUND CARE PROGRAM” | NO.  |
| TYPE: Surgical WoundsACTIONS KEY POINTS

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| Cleanse wound with wound cleanser. | Removes gross contaminants from wound bed without toxicity. |
| Allow area around wound to air dry or pat dry with gauze. | Drying allows adhesive to adhere to skin. |
| Apply calcium alginate dressing or pack calcium wound filler into the wound cavity, undermining or other tissues voids. (Do not pact too tightly). | Calcium alginate manages and absorbs excess wound fluid and maintains moist environment. |
| For Moderate draining wounds: Apply hydrocolloid over calcium alginate as a secondary dressing. This may be changed three (3) times per week unless drainage is striking through the secondary dressing more frequently. If so, this must be documented in the resident’s chart. | Provides insulation and additional absorbency. Also, protects wound from contaminants and maintains moist environment. The optimal temperature for healing is 98.6 degrees. Each time a dressing is changed, the optimal temperature for healing the wound is reduced, and it takes the body several hours to return the wound site to the optimal healing temperature; thus, it may prolong the healing process if wounds with only moderate drainage are changed daily. |
| For Heavy draining wounds: Apply foam as a secondary dressing. This may be changed daily (every 24 hours) if drainage is striking through the secondary dressing. If not, the dressing should be changed every other day. Documentation of amount of drainage is critical. | SEE ABOVE. |
| Repeat Steps 1-5 until wound drainage lessens | N/A |
| For Non-Draining wounds: Apply Hydro-gel wound filler or Hydro-gel dressing and cover with transparent dressing three times per week. | N/A |
| If calcium alginate wound filler dries on the wound, do not pull off. First, saturate the dressing with wound cleanser to re-gel or re-hydrate the dressing. Gently remove the calcium alginate. | N/A |
| Change position of resident every two (2) hours or more often according to need. | Initiate the facility’s turning and positioning and mobility programs are essential in reducing risk of pressure sores. |
| Identify and use pressure-relieving devices, i.e., special mattresses, boots chair pads, etc. | Includes review and on-going monitoring of fluid and Nutritional intake and lab value. |
| Dietician to complete nutritional assessment with appropriate recommendations and documentation. | Includes review and on-going monitoring of fluid and Nutritional intake and lab value. |
| Provide Range of Motion as indicated. | Active and Passive ROM promotes activity and reduces effects of pressure on tissue and may assist with circulation. |
| Keep family and resident informed and very involved in decisions, care planning, etc. | Encourage resident/family participation in decision process and informed of progress or lack of. |

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| Approved: | Effective Date: | Revision Date: | Change No.: | Page:  |