TREATMENT APPLICATION GUIDELINES

1. Wash hands before and after resident contact. Observe standard precautions.
2. Provide incontinence care prn to assure area is cleansed before applying treatment. Change gloves prn following incontinence care.
3. Dress chronic wounds using clean technique, since all chronic wounds are contaminated. Sterile technique is not necessary unless otherwise specified.
4. Cleanse wounds using a non-toxic agent or normal saline prior to making wound assessment and applying a new dressing.
5. Change gloves and wash hands after cleansing wounds.
6. Select a dressing that keeps the wound bed moist and the periwound skin dry.
7. Select a dressing which is at least 2” larger than the affected area.
8. Perform the wound treatment. Picture frame dressings, as needed with tape, PRN. If dressing a wound that requires packing, wash hands and change gloves before proceeding with final application.
9. After completing dressing change, remove gloves and wash hands.
10. Reevaluate dressing selection and skin integrity with every dressing change.
11. Reevaluate the wound’s response to the prescribed treatment and make recommendations for changes PRN. Inform MD of changes in wound status.
12. Use care when removing all dressings and tapes.
13. Document wound assessment, treatment performed and response to treatment on the appropriate documentation form.
14. Scabbed areas without drainage may be left open to air.

3/20/01 1 of 1