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McLAREN FLINT

WOUND CARE MANUAL

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DOING WHAT'S BEST.®

SKIN INTEGRITY DECISION TREE

RN to complete Skin assessment and Braden assessment upon admission

Score >18 without wound

- Skin assessment every 12 hours
- Braden assessment every 12 hours

Score >18 with wound

- Skin assessment every 12 hours
- Braden assessment every 12 hours
- Wound assessment with each dressing change
  - Measure wounds upon identification and weekly on Wednesday
- Treatment – Follow Instructions in Wound Care Manual
- If incontinent, apply barrier cream/wipe
- If albumin <3.0, order dietary eval
- Initiate Skin Integrity IPOC
  - Document on IPOC q shift
  - Document patient/family education q shift

WORKS CITED

Wound Care Manual – McLaren Flint

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Orsted, Heather L. Keast, David H., Forest-Lalande, Louise, Kuhnke, Janet L., O”Sullivan-Drombolis, Deirdre, Jin, Susie, Haley, Jennifer, Evans, Robyn “Best Practice and Recommendations for the Prevention and Management of Wounds”, Canadian Association of Wound Care, February 11, 2021

Ubbink, Dirk T., Brolmann, Fleur E., Go, Peter, Vermeulen, Hester “Evidence – Based Care of Acute Wounds: A Perspective” Advances in Wound Care, May 1, 2015

Yap, JiannWen, Holloway, Samantha “Evidence Based Review of the Effects of Nutritional Supplementation for Pressure Ulcer Prevention” , Wiley Online Library, September 16, 2021

Score <18 without wound

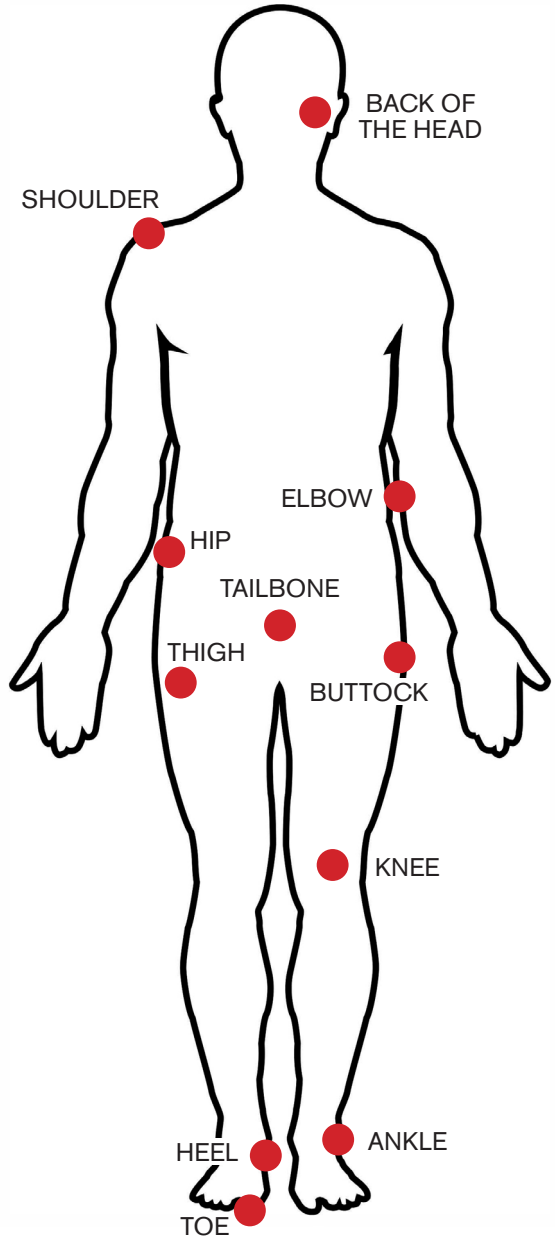
- Skin assessment every 12 hours
- Braden assessment every 12 hours
- Place patient on support surface mattress/bed
- Every two hours **TURNING** if patient is unable to reposition self
- If incontinent, apply barrier cream/wipe
- If albumin <3.0, order dietary eval
- Consider heel elevation boots and document
- Place sacral foam dressing on sacrum and document

Score <18 with wound

- Skin assessment every 12 hours
- Braden assessment every 12 hours
- Place patient on support surface mattress/bed
- Every two hours **TURNING** if patient is unable to reposition self
- Wound assessment with each dressing change
  - Measure wounds upon identification and weekly on Wednesday
- Treatment – Follow Instructions in Wound Care Manual
- If incontinent, apply barrier cream/wipe
- If albumin <3.0, order dietary eval
- Initiate Skin Integrity IPOC
  - Document on IPOC q shift
  - Document patient/family education q shift
- Consider heel offloading boots and document
- Place sacral foam dressing on sacrum if no sacral wound present and document

COMMON PRESSURE POINTS

Assess and inspect skin every 12 hours and upon admission to your unit.
Document findings in the electronic medical record.

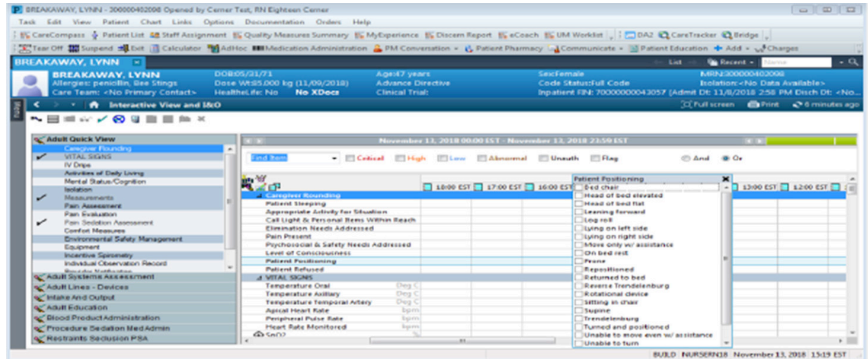


WHAT TO CHART

- Turn the patient every 2 hours, choosing a side or position. Do not simply choose repositioned.
- Detailed description of wound:
  - Location, color, drainage, odor, etc.
- Description of the dressing if recently applied
- Measurements to be taken upon admission or identification of the wound and every Wednesday throughout the patients stay
- Any preventative measures

CHARTING 2 HOUR REPOSITIONING

- To Chart Every 2 Hour Repositioning- Go to Interactive View and I&O, Caregiver Rounding (first header), Patient Positioning-Select all that apply including “Repositioned”



BARRIER CREAMS

Calazime
- Use for the treatment of open tissue on buttocks, or if somebody is having numerous loose stools.

Nutrashield
- Use for prevention for those who are incontinent.

Antifungal Cream
- Use for a fungal rash on buttocks, peri area, and skin folds.

PRODUCT FORMULARY GUIDE

Hydrofiber with silver (Opticell AG)
- Obtain from unit supply room or CART.

Hydrogel
- Obtain from unit supply room.

Silvasorb Gel
- Obtain in CART.

Hydrocolloid
- Obtain from unit supply room.

Medihoney
- Obtain from pharmacy. Physician order is required.

Silvadene Cream
- Obtain from pharmacy. Physician order is required.

Xeroform
- Moist non-adherent. Obtain from unit supply room.

Moisturizing Lotion
- Obtain from unit supply room.

USE THE WOUND OSTOMY CARE (WOC) TEAM FOR:

- Any open area to the buttocks or perineum
- Pressure Injuries (including purple discoloration suspected of being a deep tissue injury)
- Diabetic or vascular wounds that are not currently being treated by a physician
- ALL brand new ostomy patients
- For more information or questions contact a WOC nurse during normal business hours @ 22282

PRESSURE INJURY STAGE 1

Intact skin with non-blanchable redness, usually over a bony prominence.

Treatment
- Implement pressure offloading
- Turn q 2 hrs and prn
- Ensure optimal nutrition & hydration
- A non-zinc based barrier ointment can be used over the sacral/buttock area
- A foam dressing or thin hydrocolloid dressing can be applied if over a bony prominence to cushion and protect

PRESSURE INJURY STAGE 2

Intact or ruptured serlous blister.

Treatment

- If the blister is located in an area with a high probability of breaking, a xeroform and dry gauze dressing may be used to absorb fluid leakage, changing the dressing daily. The goal with any blister is reabsorption if possible.
- Pressure offloading
- Turn q 2 hrs and prn
- Ensure optimal nutrition & hydration

Partial thickness loss of dermis with red or pink wound bed.

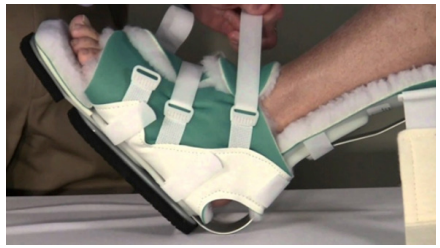
Treatment

- Open wound management: Apply either a moist non-adherent dressing or hydrogel to the wound bed and cover with gauze. Change the dressing daily
- If dressing maintenance is difficult due to urinary incontinence, discontinue dressings and utilize a non-zinc based skin barrier cream to the area. Consider a zinc based barrier cream if stool incontinence is an issue
- Pressure offloading
- Turn q 2 hrs and prn
- Ensure optimal nutrition & hydration

EHOB heel offloading boot

- Found on the unit or in CART
- Physician order is NOT needed
- Use for patients with existing heel pressure injuries, or for those at risk of developing pressure injuries
- Wedge can be positioned medially or laterally to maintain foot in upright position

Prafo boot



- Obtain through a DME. Physician order is required
- Use for patients with heel ulcers or to prevent foot drop
- Monitor patient's achilles region for signs of pressure breakdown

PRESSURE OFFLOADING DEVICES

Inflatable air overlay

- Found in CART or on the unit. To be used for patients with braden <18 and/or limited mobility or discomfort
- Physician order is NOT needed

Inflatable chair cushion

- Found in CART or on the unit.
- Physician order is NOT needed

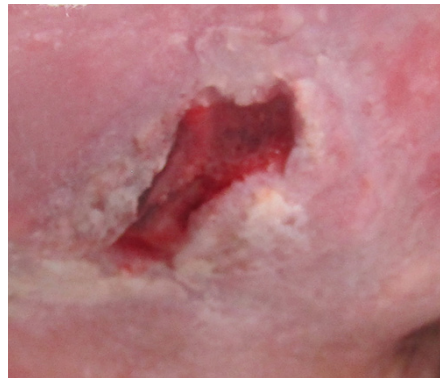
Low air loss mattress

- Ordered by the wound team or nursing supervisor
- Typically reserved for patients with pressure injuries
- Options include McLaren owned Stryker IsoTour bed or low air loss rental

**Bariatric beds with a low air loss surface are also available. Optional trapeze is available upon request. Contact the wound team or nursing supervisor to obtain

PRESSURE INJURY STAGE 3

Full thickness tissue loss: Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed.

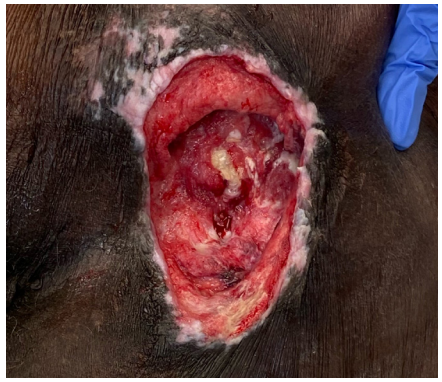


Treatment

- Cleanse with normal saline
- Dressing selection is based on wound depth and amount of drainage
  - **Minimal to moderate draining wounds with moist wound bed:** Pack with hydrogel dampened kerlix with secondary foam or ABD. This dressing is changed daily or when there is strikethrough of drainage onto the secondary dressing.
  - **Heavy draining wounds:** Consider use of a hydrofiber (obtained from cart). These products may be packed in a wound dry and covered with a secondary foam or ABD. The dressing is changed daily or when there is strikethrough of drainage onto the secondary dressing.
- Pressure offloading
- Turn q 2 hrs and prn
- Ensure optimal nutrition & hydration

PRESSURE INJURY STAGE 4

Full thickness tissue loss with exposed bone, tendon, or muscle.



Treatment

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- Pressure offloading
- Turn q 2 hrs and prn
- Ensure optimal nutrition & hydration

WHEN A WOUND OSTOMY CARE TEAM CONSULT IS NOT REQUIRED

Rash/Fungul

- Utilize antifungal cream stocked on each unit or obtain a physician's order for antifungal powder located in pharmacy

Psoriasis/Eczema/Dry Skin

- Use unit-based lotion or obtain a physician's order for lac hydrin cream located in pharmacy

Pigmented Scarring

- Monitor skin integrity & implement pressure offloading. Consider protective measures such as a non-zinc based barrier cream for moisturization or foam dressing

Abrasions/scabs/ bruising from trauma, and skin tears

- If tissue is open, follow the skin tear guidelines. If skin is intact, keep open to air

Intact, non-draining cellulitis

- Notify physician. A wound consult is only needed if open and draining

Stable callous

- Keep clean, dry, and open to air

Sutured/stapled intact incisions

- Follow the surgeon's recommendations

Routine dressing changes & wounds currently under a surgeon's care

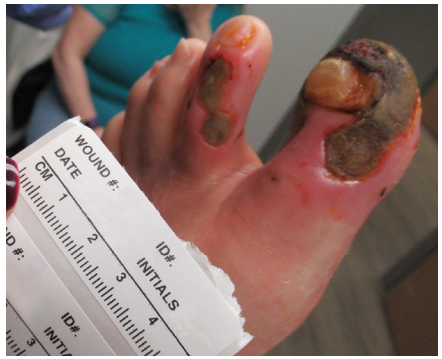
Routine Ostomy Care

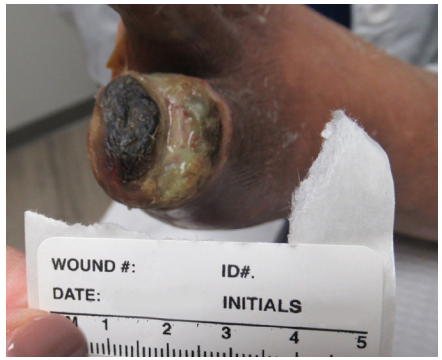
- Bedside RN to manage routine appliance changes 1-2x per week and PRN when leaking
- **EXCEPTION.** Please consult the Wound Care Team for all NEW ostomy patients so teaching can be started

1 piece ostomy kits & paste are located on every unit and in CART. Urostomy kits, 2 piece colostomy appliances, eakin rings, and clamps are located in CART

ARTERIAL INSUFFICIENCY

Dry or wet gangrene, purple discoloration, erythema.



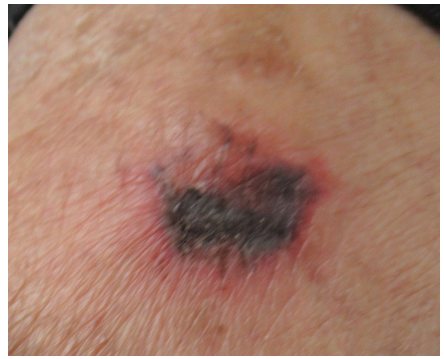


Treatment

- Keep any eschar/dry scabbing DRY! Paint with betadine. Extremity wounds that result from or are complicated by inadequate arterial circulation should be referred to a physician for management.

DEEP TISSUE INJURY

Purple or maroon area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue.

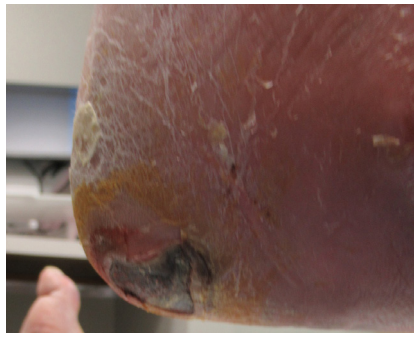


Treatment

- Pressure redistribution implementation is the primary course of treatment**
- Blood-filled blister: The goal with any blister is reabsorption if possible. If the blister is located in an area with a high probability of breaking: Apply xeroform and cover with a dry gauze dressing, changing daily, until the patient can be evaluated by the wound care nurse.
- If the blister breaks and an open wound is present, proceed with open wound management: Apply either a moist non-adherent dressing or hydrogel to the wound bed and cover with gauze. Change the dressing daily
- For intact tissue, a dressing may not be indicated. Utilize a moisture barrier until the patient can be evaluated by the wound care nurse.
- Monitor the tissue daily
- Turn q 2 hrs and prn
- Ensure optimal nutrition & hydration

UNSTAGEABLE PRESSURE INJURY

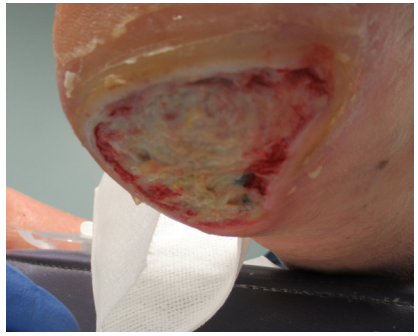
Full thickness tissue loss in which the base of the ulcer is covered by eschar or slough. Until enough slough or eschar is removed to expose the base of the wound, a stage cannot be determined.



Treatment

- Any dry stable eschar on the lower extremities should be kept dry!!! Do not apply a moist dressing unless instructed to do so by physician. May paint with providine iodine unless contraindicated.
- Monitor the tissue daily
- Maintain pressure offloading & Turn q 2 hrs/PRN
- Ensure optimal nutrition & hydration

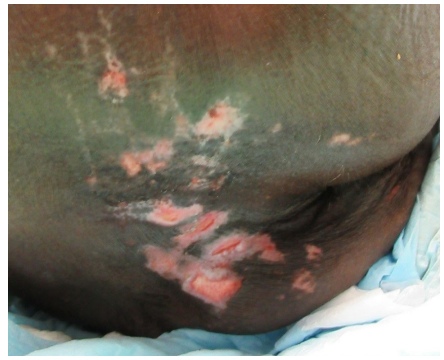
Treatment



- Moist Non-adherents or hydrogel can be used to maintain a moist wound environment in a minimally draining Unstagable pressure injury. These dressings require a secondary foam or ABD dressing. If wound depth is present, pack the wound with a hydrogel moistened gauze/kerlix dressing. A secondary foam or ABD dressing is required. Change the dressing daily & PRN
- Monitor the tissue daily
- Maintain pressure offloading & Turn q 2 hrs/PRN
- Ensure optimal nutrition & hydration

INCONTINENCE DERMATITIS

Inflammation and excoriation of the skin caused by prolonged exposure to stool or urine.



Treatment

- Consider a urinary and/or fecal collection device.
- Routinely offer assistance with toileting and check the patient frequently for incontinent episodes
- If skin is denuded or excoriated, apply a zinc-based barrier ointment with properties to adhere to wet/weeping skin
- If superficial fungal skin infection is present, apply antifungal barrier ointment. Use as ordered by the physician or wound care team.

TREATMENT OF SKIN TEARS

No need to consult the wound team unless infection is suspected or wound deteriorates.

Treatment

- **Prevention is Key!**
  Use adhesive remover on all friable skin
- **Xeroform and foam dressing.** If light drainage – change dressing every 2-3 days & prn
- **Xeroform & kerlix Roll.** For moderate to heavy drainage. Change dressing every 2-3 days & prn.
- Replace skin flap if present
- **No tape!**