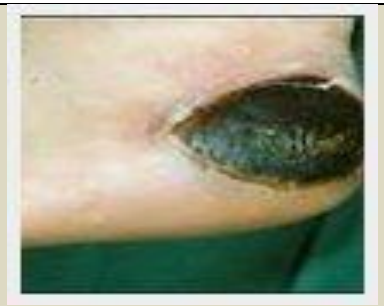
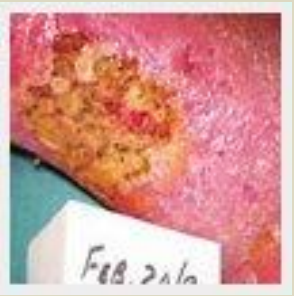
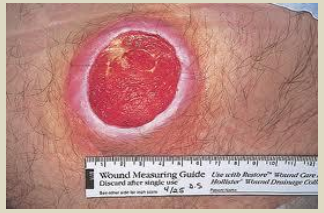
Wound Care Protocol based on wound appearance
These require PC order for treatment.

Wound Description			
	Necrotic Wound (Scab/Eschar/Dead Tissue)	Cavernous or Under-minded – Tunneled	Localized Infection/Critical Colonization (Erythematous wound & surrounds, increased drainage, possible odor, increased pain)
Goal of Treatment	Remove non-vital tissue chemically or mechanically	Potentiate granulation from bottom up and fill in dead space. Keep warm, moist & manage exudates.	Wound clean-up and reduce bacterial burden
Treatment Recommendations	MOD - HIGH EXUDATE: ** Treat underlying cause. ** Use Alginate/Hydrofiber/foam/absorptive dressing NONE - LOW EXUDATE: **Use Debridement agent / Hydrogel / Hydrogel gauze/ Saline gauze. **Sharp debridement (referral)	MOD – HIGH EXUDATE: ** Treat underlying cause. ** Use Alginate/ Hydrofiber with secondary absorbent or Hydrocapillary foam/ sponge on top. Pack lightly, cover and secure. ** Wound VAC NONE – LOW EXUDATE: ** Pack lightly with Hydrogel gauze, cover with secondary dressing, secure. ** Change daily.	MOD – HIGH EXUDATE: ** Treat underlying infection. (Topical antibiotic or antifungal; systemic antibiotic - Rx) ** Use Silver alginate/ Alginate ** Protect surrounding skin NONE – LOW EXUDATE: ** Silvadine cream topically (Rx) ** Silver wound contact layer
Helpful Care Tips		IF >1x daily dressing changes required, use of FOAM dressings as the cover/secondary dressing will help.	Do NOT use Hydrogen peroxide, Acetic Acid, Iodine, Dakin's solution, Iodophor unless specifically prescribed.
Helpful Links	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls (S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx S:\I-Teams\Wound Care\Specialist Referral, Guidelines for Wound Care Policy 12-2010.docx	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx S:\I-Teams\Wound Care\Specialist Referral, Guidelines for Wound Care Policy 12-2010.docx	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx

Wound Care Protocol

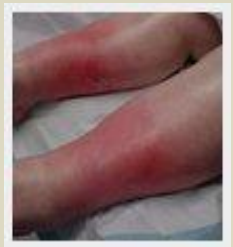
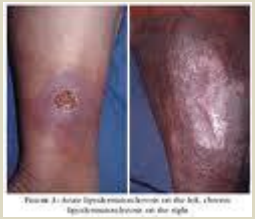
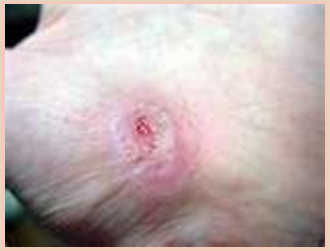
These require PC order for treatment

Wound Description			
	Sloughy Wound (Pale layer of dead or fibrinous tissue over all or part of the wound bed)	Macerated Skin (Soft, pale/white, wet or soggy skin surrounding wound)	Granulating Wound (Wound bed filled with highly vascular, fragile tissue)
Goal of Treatment	Remove non-vital tissue and management of drainage and exudates	Determine if present dressing regime is absorbing exudates. Protect surrounding skin with barrier agent.	Support granulation and tissue growth Keep wound warm and moist Manage exudates
Treatment Recommendations	MOD - HIGH EXUDATE: ** Treat underlying cause. ** Use Cadexamer Iodines/ Alginates / Hydrofibers. ** Use debridement agent NONE - LOW EXUDATE: ** Use Hydrogel/ Hydrogel gauze / Debridement agent if needed.	MOD – HIGH EXUDATE: ** Treat underlying cause. ** Use alginate or Hydrofiber and secondary absorbent dressing. ** Consider more frequent dressing changes. ** Apply barrier agent around wound bed. NONE – LOW EXUDATE: ** This does not tend to occur in none or low exuding wounds unless dressing left on too long.	MOD - HIGH EXUDATE: ** Treat underlying cause. ** Use Alginates/Hydrofiber/Absorbent pad/dressing. NONE - LOW EXUDATE: ** Non-adherent dressing or Hydrocolloid. ** Minimize dressing changes.
Care Tips		Minimize contamination from urine and feces	
Helpful Links	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx S:\I-Teams\Wound Care\Specialist Referral, Guidelines for Wound Care Policy 12-2010.docx	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls (S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx

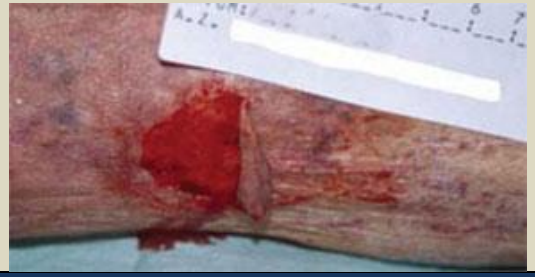
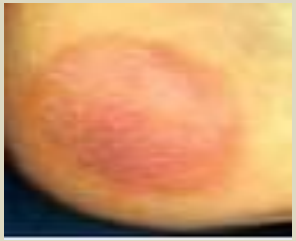
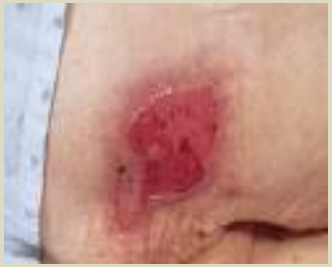
Wound Care Protocol

These require PC order for treatment

Standard NURSING Wound Care Protocol

Wound Description	 		
	Lymphedema with Venous Stasis Ulcer (Edema due to an abnormality in the lymphatic system, often involves one limb and is generally irreversible)	Epithelialization (The growth of new skin over the wound)	
Goal of Treatment	Control swelling, prevent skin ulceration and promote wound healing	Protection and continued healing	
Treatment Recommendations	GENERAL CARE: ** Cleanse w/plenty of warm water; do not soak for > 5min. Dry limb thoroughly, especially between digits and crevices. Gently remove dead skin/scaling. ** Apply Moisturizing Cream/Lotion to limb, avoiding wound. ** Choose wound dressing according to wound appearance and protocols. ** Apply **prescribed** Compression Bandage. Wrap layers from base of toes to just below tibial tuberosity for LE ulcers. Change **as prescribed**, usually MWF.	MOD – HIGH EXUDATE: ** Care per appropriate protocol. ** Protect surrounding skin. NONE – LOW EXUDATE: ** Apply thin hydrocolloid wound contact layer or ** Cover w/film dressing and secure with secondary dressing. ** Change every 3 to 5 days and as needed, monitoring for change in progress or infection.	
Care Tips	DO NOT APPLY COMPRESSION BANDAGE UNLESS COMPETENT TO DO SO	Does require PC order for treatment	
Helpful Links	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls (S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx S:\I-Teams\Wound Care\Specialist Referral, Guidelines for Wound Care Policy 12-2010.docx	

No PC order required.
"Applicable ONLY to Community Care Clinics"

Wound Description			
	Skin Tear (A break in the skin from friction, shear or trauma)	Stage I Pressure Area (Non-blanchable erythema with intact skin)	Stage II Pressure Ulcer (Partial thickness skin loss involving epidermis and/or dermis. Appears as abrasion, blister or shallow crater)
Goal of Treatment	To foster granulation and prevent infection or further trauma	To prevent deterioration of skin integrity	To foster granulation and healing
Treatment Recommendations	Gently Cleanse. If skin flap present, use sterile Q-tip or tongue depressor to approximate edges. Use Steri-Strips to secure as needed. MOD – HIGH EXUDATE: ** Apply Adaptic, dry dressing to fit and wrap with gauze to keep in place. Change daily prn. NONE – LOW EXUDATE: ** Cover with transparent dressing. Avoid significant overlapping onto healthy skin to prevent further trauma. Change q 5 to 7 days and prn.	PREVENTION: ** Position off affected area. ** Keep area clean and dry. ** Apply protective cream, WITHOUT vigorous massaging over affected area. HIGH FRICTION AREAS (i.e. heel, elbow) ** Position off affected area. ** Apply transparent dressing at least 2 inches larger than affected area. Change prn or when redness resolves. ** Consider use of heel/elbow protectors	BLISTER: ** Position off affected area. ** Gently cleanse, pat dry. ** Cover with transparent dressing 2 inches larger than ulcer. Apply without tension or wrinkles. Change PRN. ABRASION/SHALLOW CRATER with minimal to moderate amount of drainage: ** Position off affected area. ** Gently cleanse, pat dry. ** Apply Hydrocolloid or Foam dressing of appropriate size. Change q 5-7 days and prn.
Helpful Links	http://www.dressings.org (S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx S:\I-Teams\Wound Care\Wound documentation.docx	http://www.dressings.org (S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx S:\I-Teams\Wound Care\Wound documentation.docx	http://www.dressings.org S:\I-Teams\Wound Care\Skin Care Products.xls S:\I-Teams\Wound Care\Specialty Mattresses 03-2011.docx S:\I-Teams\Wound Care\Wound documentation.docx

Standard NURSING Wound Care Protocol

No PC order required.

Wound Description	 Fungal Skin rash (Moist, macerated, erythemic plaques and erosions found most commonly in folds of abdomen, groin or breast. Satellite papules commonly seen.)	**General Wound Care Guidelines** 1. The following general wound care guidelines should be followed for ALL members with wounds. For specific treatments, see Wound Care Protocols. 2. Clean technique should be used for wound care. All wounds are considered contaminated unless otherwise ordered. 3. Normal Saline is used to cleanse wound, unless contra-indicated. Cleanse prior to any wound assessment or new dressing application. 4. Apply Skin Protectant prep to wound borders and under any adhesive. 5. Select dressings that keep wound bed moist and peri-wound skin dry. 6. Document wound assessment weekly per policy and as needed when there is a change. 7. Evaluate dressing selection and skin integrity with each dressing change. 8. Know the indications and contra-indications of the wound care products you are using. Utilize the www.dressings.org website. 9. Use care when removing all dressings and tapes to maintain progress of wound healing. Use adhesive remover prn. 10. Consider consultation with nutrition and rehab services. 11. Observe for signs and symptoms of infection: Erythema, warmth and edema of the skin and tissue surrounding the wound Pain or increased pain Purulent drainage or foul odor Fever, chills and malaise REPORT symptoms of infection to PC Adapted from 2004 Wound Care Guidelines, St. Joseph's Community Hospital of West Bend.
Goal of Treatment	Clean, dry skin without infection	
Treatment Recommendations	PREVENTION: ** Avoid causes of friction: tight or chafing clothes, activities causing skin on skin rubbing, obesity. ** Maintain glucose control. ** Keeping skin clean, dry and protected. ** Management of causative factors such as hygiene, urine or fecal incontinence. TREATMENT: ** Cleanse and dry well before every treatment. ** Apply Baza/Miconazole cream (from stock) around and to affected area TWICE daily and as needed. ** If no improvement after 3 to 5 days, consult with PC. FUTURE PREVENTION: ** After resolution, Miconazole powder may be applied to affected areas daily to prevent recurrence.	**Wound Protocol Reference List** 1. St. Joseph's Community Hospital of West Bend, WI. 2004. Skin and wound care treatment protocols. 2. Wound, Ostomy and Continence Nurses Society. Various resources, website. 3. Bakerjian, D & Levenson, S. 2008. Reducing pressure ulcers in NHs: An interdisciplinary process framework. www.nhqualitycampaign.org 4. Coloplast. 2007. Wound care reference guide. www.coloplast.com 5. Northern Health and Social Services Board 2005. Sound management manual. www.nhssb.n-i.nhs.uk/publications/primary_care/Wound_Manual.pdf 6. Up-to-Date on line 18.2. 2010.
Helpful Links	http://www.dressings.org (Skin Care Products.xls) S:\I-Teams\Wound Care\Wound documentation.docx	