Wound Care Protocol

Presented by:
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Primary Care Provider – Wound Care Protocol

WOUND CARE PROTOCOL – PRIMARY CARE PROVIDER

1. Principles of wound bed preparation MUST be adhered to:
   a. Debridement of dead tissue, except in dry diabetic, gangrene, and ischemia; Proper equipment and training for debridement are ESSENTIAL for professionals treating wounds.
   b. Moisture balance: Infected wounds require antimicrobial products for local infection and antibiotic for systemic infections.
   c. Partial thickness wounds require antimicrobial products.
   d. All diabetic wounds require antimicrobial products.
   e. Optimize wound health by attention to nutrition, blood supply avoiding smoking, offloading pressure and control, etc. (treat the whole person)
   f. Diagnose etiology of wound may be multifactorial, e.g. trauma, trauma, diabetes, and/or ischemia.

Frequency of visits and treatment products may change at the discretion of the nurse wound care therapist, as per clinical assessment, in accordance with the ICPs. Treatment will be taught to the patient/caregiver as appropriate.

The following wound descriptors can be used to select the appropriate dressing protocol. If no selection is made, the nurse will initiate the plan of care as per ICPs and communicate on the status of the wound to the primary care provider.

**Superficial Granulating Wound**
- Minimum Exudate: Hydrogel/Alginate (Every 3-7 days)
- Moderate to Severe Exudate: Foam Dressing (Every 3-7 days)

**Cavity Wound**
- Minimum exudate: PNMT/Adhesive Gauze/Kerlix Roll (Every 2-5 days)
- Moderate to Severe exudate: Hydrofiber/Calcium Alginate (Every 3-7 days)

**Burn Wound**
- Minimum exudate: Nanocrystalline Silver (Every 3-7 days)
- Moderate to Severe exudate: Hydrofiber with Silver + Change cover dressing and non-adherent Hydrofiber (Every 3-5 days)

**Chronic Non-healing Wound**
- Minimum exudate: Calcium Alginate + Silver + Change cover dressing and non-adherent Alginate (Every 3-5 days)
- Moderate to Severe exudate: Flammazine - Requires Physician Rx (Twice a week)

**Pressure Ulcer**
- See Infected wound, Cavity Wound, or Superficial Wound.

**Infected Wound**
- Cadexomer Iodine dressing – e.g. Iodosorb (Every 5 days)
- Delayed release Iodine Dressing (Iodine) (Every 3 days)
- Hydrogel with Silver (Every 2-3 days)
- Hydrofiber with silver (Every 3-7 days)
- Calcium Alginate with silver (Every 7 days)
- PRP/HB/Adhesive Gauze/Kerlix Roll (Every 2 days)
- Gentian Violet + Methylene Blue (Hydrofera Blue) (Every 3-7 days)
- Pseudomones infection: acetic acid (vinegar) 2.5% (3% diluted 1:1 with saline or water) soaked gauze RTO 1-2 days; then revert to appropriate dressing for infected wound

**Intertrigo**
- Textile with Silver/Integrity Ag in Skin folds can be hand-washed, hung to dry, and reused, if appropriate, as the sole product. (i.e. No creams or ointments)
- PRP/HB/Adhesive Gauze/Kerlix Roll (Antimicrobial dressing - apply as the sole product - Every 3 days)

**Venous Status Ulcer**
- ABI or vascular study required prior to initial treatment. ABI may not be accurate in diabetic and elderly patients – Vascular studies required, and patients must be followed by wound care specialist.
- Compression is the cornerstone of treatment: Life long compression is necessary once ulcers heal.
- Compression bandage - Coban if ABI 0.8-1.2 Coban lite if ABI <0.8
- Elastic bandage (Singap) to knee if ABI 0.6-0.8

**NPWT: VAC**
- Moderate to heavily exuding wounds
- All must be referred to local specialist or wound doctor

**NPWT: PICO**
- Light to moderate exuding wounds

**NPWT: PICO**
- Wound dressing - Size Small, Medium, Large
- Filler - White Foam, Foam Band
- Settings - Every 3 days (cannot be left in place longer than 3 days), if necrotic wounds, must be assessed immediately or changed to conventional dressing if VAC is not available at that time

**NPWT: PICO**
- Necrotic Wound
- Hydrogel for subacute debridement (CONTRAINDICATED in ISCHEMIC WOUNDS: Vascular assessment necessary. Sharp debridement is CONTRAINDICATED without vascular assessment)
- Calcium Alginate (Iodine) at the margins of dry eschar
- Dry ischemic wounds: Paint with Betadine solution daily, cover with dry gauze PNP

INITIALS: ___________________________ DATE: ________________

**PRINTED NAME/DESIGNATION:** ____________________________

**SIGNATURE:** ____________________________

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Principles of wound bed preparation

- Debridement
- Moisture balance
- Bacterial balance
5 Tips for the Clinician

- Assess patient and patient’s wound with each dressing change.
- Keep dressing as thin as possible in the plantar surface.
- If packing, wick it. Remember, “Fluff. Don’t stuff”.
- Temperature of affected limb is important. It may indicate infection, inflammation and/or decreased vascular supply.
- Listen to the patient and/or his circle of care.

Clinical Pathways

- Diabetic foot ulcer
- Surgical wounds
- Pressure ulcers
- Venous stasis ulcers
- Chronic maintenance wounds
- Infected surgical wounds
- Pilondial sinus / incision and drainage
- Trauma wound
- Atypical wounds
- Burns
# Product Picker

## Dressing Selection Guide

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**Caution**

Dressing selection cannot be considered in isolation. Local wound care, including dressing selection, must be determined after a holistic patient assessment, including treating the cause and addressing patient-centered concerns. It is recommended that a validated and responsive tool be used to assess and reassess chronic wounds.

Clinicians need to decide if the wound is:

- Healed: All causes and co-factors that may interfere with healing have been removed and healing is proceeding in a timely fashion.
- Non-healing: Causes of the wound cannot be removed. Most Interactive wound healing is contraindicated.
- Stalled: Consult wound specialist.

**Additional Resources**

Superficial granulating wound
Products

Minimum exudate
- Hydrogels
- Hydrocolloids

Moderate to severe exudate
- Hydrofibers
- Calcium alginites
- Foams
Cavity wound
Products

Minimum exudate

PHMB

Moderate to Severe exudate

Hydrofiber, calcium alginate and foam
Burns

- Nanocrystalline silver
- Hydrofiber with silver
- Flamazine
- Polysporin to face
Chronic wounds

Inadine and Iodosorb

PHMB

Silver products
Infected wounds
STAGES OF INFECTION

- **Contaminated**: Host in control
- **Colonized**: Established bacterial population, host control bacterial balance
- **Critically Colonized**: Established bacterial population, wound not progressing, bacterial imbalance, no signs of infection
- **Infected**: Bacteria in control

TREAT WITH:
- Topical Antimicrobials
- Systemic Antibiotics

Adapted by P. Coutts from D. Keast and P. Bowler
Products

• Antimicrobial dressings
  – Silver
  – Iodine
  – PHMB

• Acetic acid
Intertrigo
Venous stasis ulcers

**Dressings:**
- calcium alginate with AG
- hydrofiber with silver
  - PHMB
- Iodine dressing

Compression bandages
Necrotic wounds

- Autolytic debridement
- Autolytic debridement contraindicated in ischemic wounds
- Inadine or Iodosorb
- Betadine solution painted on
Use of NPWT and Disposable Negative Pressure

VAC

QUANTUM

PICO
Medical Professionals:
The first people you see after saying: “Hold my beer and watch this”.