WOUND PRODUCT SELECTION PROTOCOL

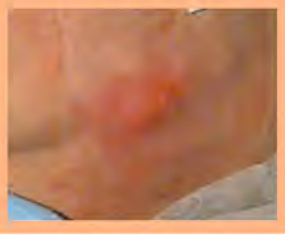
Beebe Healthcare
CREATING THE NEXT GENERATION OF CARE

STEP 1
WOUND ASSESSMENT

- Perform head-to-toe assessment on every shift
- Remove Dressing and assess location, stage, LxWxD in cm, undermining, tunneling, tissue type (e.g., granulation, epithelial tissue, eschar, slough), exudate (amount, type & character), odor, surrounding skin, presence or absence of infection, wound edges, pain at site).
- NOTE: Wounds that are not over a bony prominence and/or, not related to pressure from a device, are NOT staged. They are classified as full-thickness or partial-thickness wounds.
- Assess the wound on admission, weekly, with significant changes, and day of discharge
- Assess heels at every shift, Remove and reapply compression stockings and/or heel boot if present

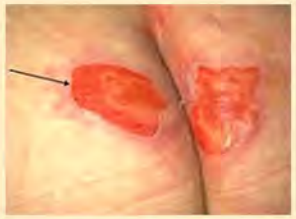
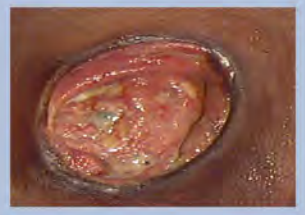
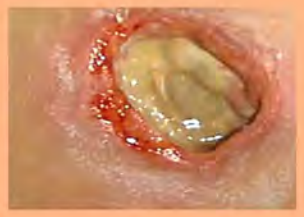
STEP 2:
PRODUCT SELECTION

- Choose the appropriate primary and secondary dressings from the Wound Product Selection Protocol

WOUND TYPE		TREATMENT
Intact Skin or Incontinence Associated Dermatitis (IAD) 		**❑INTACT SKIN** ●Cleanse with Perineal Skin Cleanser. ●Apply Barrier Cream. **❑NON INTACT SKIN (iad)** ●Cleanse with Perineal Skin Cleanser. ●Use Protective Barrier Cream. **❑FECAL CONTAINMENT DEVICE INSERTION, INTERNAL** ●Refer to Lippincott Procedure Job Aide for candidate selection and product use guidelines, obtain from Central Distribution.
Skin Tears 		**DRY/LIGHT EXUDATE** **❑Skin tear that is dry or with scant amount of drainage** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hydrogel covered with gauze dressing and kling once daily. ●Date and initial dressings at every change. **❑Skin tear with small amount of drainage:** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply non-adherent dressing (Adaptic Touch), gauze and Kling every 3-5 days. Outer dressing should be changed with strike through. ●Date and initial dressings at every change. **MODERATE/HEAVY EXUDATE** **❑Skin tear with moderate/large amount of drainage** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Foam with Adhesive Border every 3-5 days and PRN. ●Date and initial dressings at every change. **NOTE: Refer to Wound Care Nurse and Physician, NP or PA if skin tear(s) do not improve or worsen.**
STAGE 1 Pressure Injury Intact Non-Blanchable Erythema of Intact Skin 	Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes.Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.	**❑DRY/LIGHT EXUDATE** ●Cleanse with Bath Wipes or mild soap and water. ●Apply Skin Barrier Wipe and let dry or apply Barrier Cream every shift.

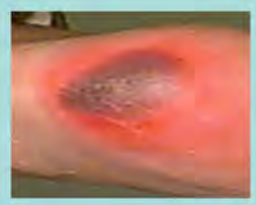
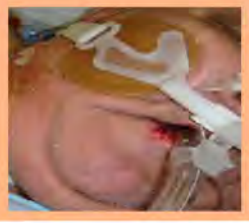
Beebe Healthcare
CREATING THE NEXT GENERATION of CARE

WOUND PRODUCT SELECTION PROTOCOL

WOUND TYPE		TREATMENT	
Stage 2 Pressure Injury Partial-Thickness Skin Loss with Exposed Dermis 	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).		❑**DRY/LIGHT EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Foam with Adhesive Borderevery 3-5 days and PRN. ●Date and initial dressings at every change. ❑**MODERATE/HEAVY EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hydrofiber Silver Dressing and cover with Foam with Adhesive Border every 3-5 days orwhen saturated. **NOTE: Do not use Hydrofiber Silver Dressing if patient has an allergy to silver.** ●Date and initial dressings at every change.
STAGE 3 Pressure Injury Full-thickness Skin Loss 	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.	❑**DRY/LIGHT EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Foam with Adhesive Border every 3-5 days and PRN. ●Date and initial dressings at every change. ❑**MODERATE/HEAVY EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hydrofiber dressing and cover with Foam with Adhesive Border and change every 3-5 days or when saturated. ●Date and initial dressings at every change. ❑**Infected wounds:** ●Refer to Wound Care Nurse and Physician, NP or PA.	●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hydrofiber Silver Dressing and cover with Foam with Adhesive Border every 3 -5 days and PRN. **NOTE: Do not use Hydrofiber Silver Dressing if patient has an allergy to silver.** ●Date and initial dressings at every change. ❑**WOUNDS WITH DEPTH:** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Fill wound bed with Hydrofiber Silver Rope and cover with Foam with Adhesive Border every 3-5 days and PRN. **NOTE: Do not use Hydrofiber Silver Dressing if patient has an allergy to silver.** ● Date and initial dressings at every change.
Stage 4 Pressure Injury Full-thickness Skin and Tissue Loss 	Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.	❑**DRY/LIGHT EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Foam with Adhesive Border and change every 3-5 days and PRN. ● Date and initial dressings at every change. ❑**MODERATE/HEAVY EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hydrofiber dressing and cover with Foam with Adhesive Border and change every 3-5 days or when saturated. ●Date and initial dressings at every change.	❑**INFECTED WOUNDS** ●Refer to Wound Care Nurse and Physician, NP or PA. ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hydrofiber Silver Dressing and cover with Foam with Adhesive Border every 3-5 days and PRN **NOTE: Do not use Hydrofiber Silver Dressing if patient has an allergy to silver.** ●Date and initial dressings at every change. ❑**Wounds with depth:** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Fill wound bed with Hydrofiber Silver Rope and cover with Foam Adhesive Border every 3-5 days and PRN. **NOTE: Do not use Hydrofiber Silver Dressing if patient has an allergy to silver.**
Unstageable Pressure Injury with Slough 	**Obscured full-thickness skin and tissue loss** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.	**DRY/LIGHT EXUDATE** ❑**SUPERFICIAL SLOUGH**: ● Cleanse with Normal Saline. ● Apply Skin Barrier Wipe to peri-wound and let dry. ● Apply Collagenase topically once daily, thickness of a nickel, cover with gauze and secure with silicone or paper tape or apply Iodoflex, cover with gauze and secure with silicone or paper tape every 2-3 days. **NOTE: Do not use Iodoflex if patient has an allergy to iodine.** ● Date and initial dressings at every change. ❑**Thick Slough** ●Consult physician for surgical debridement. ❑**Post Debridement: For wound with yellow, green, or brown slough: Refer to Wound Care Nurse**	● Cleanse with Normal Saline or Wound Cleanser. ● Apply Skin Barrier Wipe to peri-wound and let dry. ● Apply Hypertonic Impregnated Gauze, cover with gauze, secure with silicone or paper tape and change once daily or PRN. ●Date and initial dressings at every change. ❑**MODERATE/HEAVY EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hypertonic Impregnated Gauze, cover with gauze, secure with silicone or paper tape and change once daily or PRN. ● Date and initial dressings at every change.

Beebe Healthcare
CREATING THE NEXT GENERATION of CARE

WOUND PRODUCT SELECTION PROTOCOL

WOUND TYPE		TREATMENT
Unstageable Pressure Injury With Dry Eschar 	**Obscured full-thickness skin and tissue loss** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.	**LIGHT EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply Hydrogel and Gauze. Secure with silicone or paper tape once daily. ●Date and initial dressings at every change. ❑**Dry** **Note: DO NOT debride or use a dressing on dry, black stable eschar on heels and/or feet if non-fluctuant, nonerythematous, or nonsuppurative. Leave open to air.**
Deep Tissue Pressure Injury (DTPI) 	**Persistent non-blanchable deep red, maroon or purple discoloration** Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.	**DRY/LIGHT EXUDATE** ❑**Intact Skin:** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Apply topical (Balsam Peru/Castor Oil) every 12 hours (no dressing needed). ❑**Non-intact skin:** ●Follow treatment for pressure injury as assessed, staged and outlined above.
Medical Device Related Pressure Injury 	**Use Staging System** Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.	❑**DRY/LIGHT EXUDATE** ● Cleanse with Normal Saline or Wound Cleanser. ● Apply Skin Barrier Wipe to peri-wound and let dry. ● Follow treatment for pressure injury as assessed, staged and outlined above.
Mucosal Membrane Pressure Injury 	Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.	❑**DRY/LIGHT EXUDATE** ●Cleanse with Normal Saline or Wound Cleanser. ●Apply Skin Barrier Wipe to peri-wound and let dry. ●Reposition medical device to prevent pressure to the site.

WOUND PRODUCT SELECTION PROTOCOL

IF ADVERSE REACTION OCCURS:

- Discontinue Treatment
- Reassess Wound
- Notify Physician, NP or PA to obtain order for another Treatment

INDICATIONS TO DISCONTINUE PROTOCOL

- Wound has Healed
- Allergic Reaction Occurs

Stage 3, 4 and Full Thickness wounds may require the use of NPWT if ordered.

Use only paper or silicone tape, or non-woven fabric tape. (Cover-Roll-Stretch)
For an extremity, wrap with soft gauze (Non-stretch (Kling) or Stretch Roll Gauze) and secure with tape.
If patient is sensitive to tape, apply Skin Barrier Wipe, allow it to dry,
and then apply tape over the Skin Barrier Wipe.

If wound is not healing, **CONSULT THE PHYSICIAN, NP, or PA.**

Refer to the following policies for further information:

- Pressure Injury Prevention and Treatment Plan
- Negative Pressure Wound Therapy
- Prevention, Assessment and Treatment of Skin Tears