

Improving Compliance with "Nurse Friendly" Wound Dressings and Protocols

PROTOCOL FOR PRESSURE ULCER TREATMENT STAGE I OR SUSPECTED DEEP TISSUE INJURY (SDTI)

Simplified Wound Care Protocols

1. Location of ulcer (U): _____
2. Implement and print protocol for Skin Assessment and Pressure Ulcer Prevention from Medica.
3. Place the patient on a **ZonedAir® Bed** or **Venacare A.L.R.® Bed**, unless the patient is in a critical care unit on a **Total Care Specific® bed** then use the **Optimize Mode** if the rotation mode is not being utilized in the bed.
4. Choose and check the appropriate dressing:
 - Primary goal is to provide pressure relief to reddened area.
 - If reddened area is at/over perineum and patient is incontinent: _____
 - For Suspected Deep Tissue Injury (SDTI) over bony prominence: **Moisture**
 - If intact skin is deep red/bruised or purple color with or without thin fibrinous exudate: _____
 - If intact skin is deep red/bruised or purple color with or without thin fibrinous exudate: _____



PROTOCOL FOR TREATMENT STAGE II PRESSURE ULCER (PTU) (PARTIAL THICKNESS WOUND) (PTW) OR SKIN TEARS

Simplified Wound Care Protocols

1. Consult a dietitian. Diet: _____
 2. Location of ulcer (U): _____
 3. Implement and print protocol for Skin Assessment and Pressure Ulcer Prevention from Medica.
 4. Place the patient on a **ZonedAir®** or **Venacare A.L.R.® Bed**, unless the patient is in a critical care unit on a **Total Care Specific® bed** then use the **Optimize Mode** if the rotation mode is not being utilized in the bed.
 5. Cleanse the wound(s) with (choose one): **SB** or **Venous Cleanser** _____ and gauze.
 6. Dry well.
 7. Choose and check the appropriate dressing for stage (U) (PTW): _____
- For multiple wounds on an extremity:
- Apply **Venous®** gauze and **Kerlix®** or **ADDS®** and paper tape for fragile periwound skin daily and per.
 - If wound is lightly to moderately draining: _____
 - Cover wound base with **Mepilex® Border** dressing. Change every 3 days and per as needed. Do not use **SB** or **Cariflex** skin prep with **Mepilex® Border** dressing.
 - If breakdown is at periwound with an incontinent patient, use a thick moisture barrier: **Amulet®**, **OptiGel®**, **Cariflex®** or **ADDS®** (perifol) and per.



Sheila Carter MSN, RN, FNP-BC, CWON, CFCN
 Patricia Moore RN, CWCN
 Jennifer Vandiver BSN, RN, CWON
 Hope Voegeli RN, CWON
 Jackson Madison County General Hospital
 Jackson, Tennessee

Simplifying Wound Care Protocols to Improve Nursing Compliance and Patient Care

The Wound Ostomy Continence (WOC) nurses at Jackson Madison County General Hospital have developed over the years eight wound and skin care protocol orders. This has recently been reduced to six.

- Protocol for Skin Assessment & Pressure Ulcer Prevention
- Protocol for Pressure Ulcer Treatment Stage I or SDTI
- Protocol for Pressure Ulcer Treatment Stage II/PTW/Skin Tears
- Protocol for Pressure Ulcer Treatment Stage III/IV/FTW
- Protocol for Skin Folds
- Protocol for Dry Skin and Incontinence Care

The original eight protocols were combined to simplify protocol use and to offer a dressing that is suitable for multiple wound types, easy to apply and remove. Now protocol implementation is much easier for the nurses and patient care and comfort has been improved in every way.

WOC nurse consults for skin tears have decreased since the Mepilex® Border dressings were initiated. Our nurses are much more confident with their dressing choices because of the versatility and appropriateness for multiple wound types.

Benefits of Border Foam Dressing

Patients

- Atraumatic to the wound and surrounding skin upon removal
- Does not adhere to moist wound
- Adheres gently and securely to dry, intact surrounding skin
- Maintains a moist wound environment
- Minimizes the risk of maceration
- Patient comfort, minimizes pain
- Moisture proof and bacteria proof film backing

Nurses

- Easy to apply
- May be lifted to assess wound and readheres to skin
- 3-7 day dressing change
- Waterproof for incontinent patients
- May be used on multiple wound types
- Better exudate management
- Minimizes odor



PROTOCOL FOR TREATMENT STAGE III/IV UNREPAIRABLE PRESSURE ULCER AND FTW (FULL THICKNESS WOUND)

1. Consult the dietitian. Diet: _____
 2. Location of pressure ulcer (U) or skin tear: _____
 3. Implement and print protocol for Skin Assessment and Pressure Ulcer Prevention from Medica.
 4. Place the patient on a **ZonedAir®** or **Venacare A.L.R.® Bed**, unless the patient is in a critical care unit on a **Total Care Specific® bed** then use the **Optimize Mode** if the rotation mode is not being utilized in the bed.
 5. Cleanse the wound(s) with (choose one): **SB** or **Wound Cleanser** _____ and gauze.
 6. Dry well.
 7. Select and check the appropriate dressing: _____
- For light to moderate draining wounds: apply **colloid adhesive** (Mepilex®) dressing and cover with a transparent film dressing (Pro-Adhese, OptiGel®) or apply **Mepilex® Border** dressing. Change every 3 days or per with increased drainage/odors. **SB**, **SB**, **SB**, **SB** (Cariflex Skin Prep with Mepilex®).
- For heavy draining wounds: apply **colloid adhesive** (Mepilex®) and cover with **ADDS®** and paper tape and change daily and per with dressing change.
- For deep wounds: apply **hydrogel** (Cariflex®, **Red gel**) and cover or **lightly pack** wound with **moist gauze** of the selected material (Cotton, **Cariflex** or **ADDS**) and paper tape. Change daily and per with dressing.
- For wounds totally covered with dry exudate: cover with the **periwound dressing** if needed and followed by **SB** or **WOC** (Cariflex, **ADDS**) and paper tape and change daily and per with dressing change.

Simplified Wound Care Protocols

