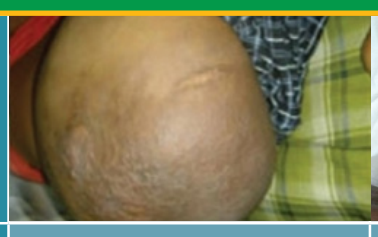
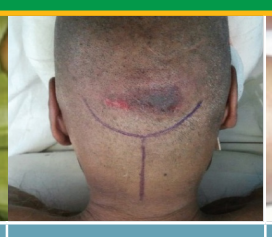
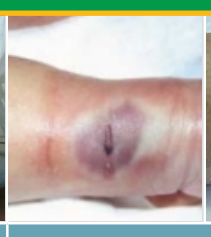
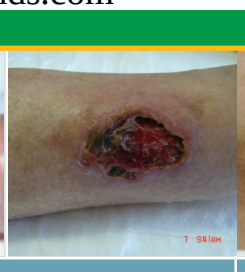
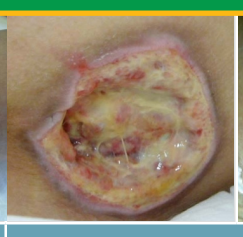
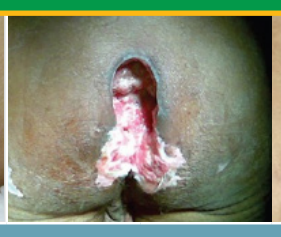
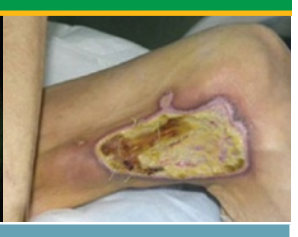
IN CARE PROTOCOL BY COMPREHENSIVE WOUND CARE SERVICES

Certified | Cost Control | Compassion

Info@cwswounds.com

We Heal Wounds

Wound Images							
Wound Type	**Suspected Deep Tissue Injury**	**Stage I Pressure Ulcer**	**Stage II Pressure Ulcer or Partial Thickness wound**	**Stage III Ulcer or Full Thickness Wound**	
Definition	**sDTI** – Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep Tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing of additional layers of tissue even with optimal treatment. NPUAP 2019	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; it's color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons. NPUAP 2019	**Stage II or Partial thickness loss** of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This stage should not be used to describe skin tears, tape burns, incontinence associated with dermatitis, maceration or excoriation. *Bruising indicated deep tissue injury. NPUAP 2019	**Stage III or Full Thickness** – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significantly adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable. NPUAP 2019	**Stage IV or Full Thickness** – Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable. NPUAP 2019
Treatment		**Dry to Scant**	**Moderate to Heavy**	**Dry to Scant**	**Moderate to Heavy**
	PREVENTION GUIDELINES • Pressure redistribution support surface as appropriate • Turn and reposition q 2h in bed and q 1h in chair • Offloading device to keep heels elevated off bed • Monitor skin at least q 8hrs PREP, IF APPROPRIATE • No sting sure prep MOISTURIZE, IF APPROPRIATE • Remedy Nourishing Skin cream PROTECT, IF INCONTINENT • Moisture Barrier ointments and protectants, as appropriate	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin APPLY • Skintegrity Hydrogel – Change Q 3days and PRN COVER • Bordered Gauze	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin APPLY • Exuderm Odorsheild – change Q 3-5 days and PRN OR • Optifoam/ Optifoam Gentle – change Q 3-5 days and PRN	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin APPLY • Debridement agent, qdaily FILL, IF NEEDED • Skintegrity Hydrogel and Gauze – change Q 3 days and PRN COVER • Bordered Gauze • Optifoam/Optifoam Gentle	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin FILL • Debridement agent, qdaily COVER • Bordered Gauze • Optifoam/Optifoam Gentle **STALLED WOUNDS – PARTIAL/FULL THICKNESS • Puracol Plus – Change Q 3-5 days and PRN

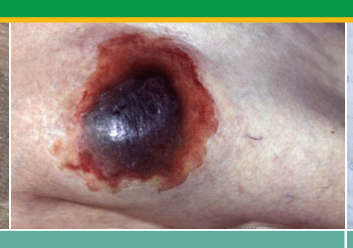
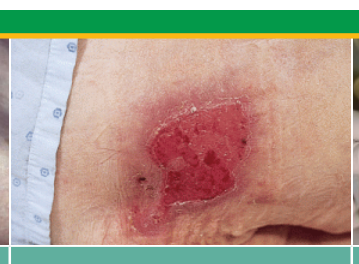
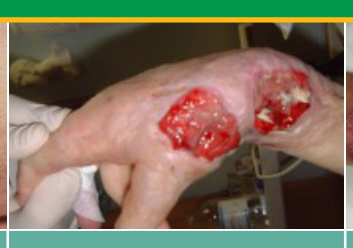
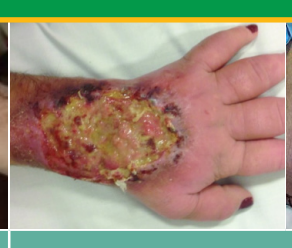
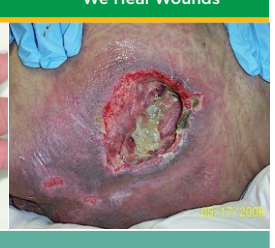
1 of 3

IN CARE PROTOCOL BY COMPREHENSIVE WOUND CARE SERVICES

Certified | Cost Control | Compassion

Info@cwswounds.com

We Heal Wounds

Wound Images						
Wound Type	**Unstageable Pressure Ulcers Necrotic wounds**	**Skin Tear Type 1 or 2**	**Skin Tear Type 3**	**Colonized or Infected Wounds**	
Definition	**Unstageable** – Full thickness skin or tissue loss - Depth unknown. Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth can not be determined; but it will be either a Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. NPUAP 2019	**Type 1** – No Skin Loss. Linear or flat tear which can be repositioned to cover the wound bed **Type 2** – Partial Flap Loss. Flap cannot be repositioned to cover the wound. NPUAP 2019	**Type 3** – Total Flap Loss. Entire wound bed is exposed NPUAP 2019	**Colonized** – Presence of bacteria that cause no local or systemic signs or symptoms.	**Infected** – represents the invasion of bacteria into healthy tissue where they continue to proliferate and cause a reaction from the host – will typically show signs of clinical infection, need Topical/Systemic ABX
Treatment		**All Levels**	**Dry to Scant**	**Moderate to Heavy**	**Dry to Scant**	**Moderate to Heavy**
	• Solid Dry Eschar on Heels – No dressing, keep dry	OTHER NECROTIC WOUNDS CLEANSE • Saline PREP • Surprep No-Sting to periwound skin APPLY • TheraHoney – change Q 3-5 days and PRN COVER • Bordered Gauze, Optifoam Gentle	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin APPLY • Skintegrity Hydrogel, change Q 3 days and PRN COVER • Rolled Gauze/tape OR APPLY • Optifoam Gentle – Change Q 3-5 days and PRN	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin APPLY • Optifoam Gentle, change Q 3-5 days and PRN	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin FILL • SilvaSorb Hydrogel, change Q 3 days and PRN COVER • Bordered Gauze Debridement agent	CLEANSE • Saline PREP • Surprep No-Sting to periwound skin APPLY • Opticell Ag, change Q 3-5 days and PRN COVER • Bordered Gauze or Optifoam Gentle Antibiotic Powder with debridement agent. ABX PO as per PCP

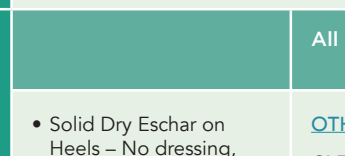
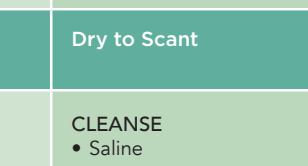
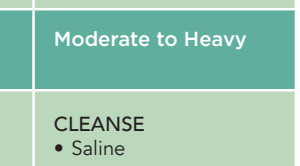
2 of 3

IN CARE PROTOCOL BY COMPREHENSIVE WOUND CARE SERVICES

Certified | Cost Control | Compassion

Info@cwswounds.com

We Heal Wounds

Routine Skin Care	High Risk Skin	Incontinence	Incontinence Associated Dermatitis (IAD)	Weepy Edema	Intertrigo	Fungal Rash
						
Everyday skin care for patients with no skin related issues	Skin care for those at high risk for breakdown or for sensitive skin	Moisture barrier for those patients who are incontinent to provide protection where skin is intact.	Skin protectant and treatment for those patients who are incontinent and where skin is compromised or with epidermal skin loss.	Protectant barrier and treatment for compromised, weepy skin	Protection and treatment for areas exposed to friction and moisture where there is skin to skin contact	Protection and treatment of fungal rash
Current						
1. Cleanse and dry area thoroughly 2. Apply skin cream while skin is damp, when possible 3. Apply skin cream only to point where cream disappears 4. Avoid massaging red, bruised, or discolored skin, or over a bony prominence 5. Inspect skin for signs of breakdown especially over bony prominences and under breasts, abdominal folds, axilla areas, heels and ankles 6. Remove socks or support hose daily to inspect feet for signs of pressure or skin breakdown	1. Cleanse and dry area thoroughly 2. Protect skin after cleansing wit barrier cream 3. Apply barrier cream to intact skin and reapply as needed 4. Inspect skin with each cleansing to identify early breakdown	1. Cleanse and dry area thoroughly 2. Protect skin after cleansing with skin protectant paste 3. Apply skin protectant paste to denuded or macerated skin until entire area is covered 4. Utilize a thin layer, and cleanse soiled area only until clean. It is not necessary to remove all of the skin protectant paste 5. Inspect skin with each cleansing	1. Cleanse and dry area thoroughly 2. Apply skin protectant paste to compromised weepy skin 3. Avoid putting skin protectant paste in between the toes	1. Cleanse and dry area thoroughly 2. Apply skin protectant paste to denuded or macerated skin until entire area is covered 3. Implement measured to prevent friction and moisture in skin fold areas 4. May also need anti-fungal treatment	1. Cleanse and dry area thoroughly 2. Apply anti-fungal powder or cream to fungal rash 3. Consider treating fungal rash for 14 consecutive days, even if rash improves
Future						
1. Bathe with Soothe and Cool Herbal Shampoo and Body Wash. *Dry area thoroughly* 2. Apply Remedy Phytoplex Nourishing Skin Cream while skin is damp, when possible. • Apply moisturizing only to point where lotion/ cream disappears • Avoid massaging red, bruised, or discolored skin, or over a bony prominence • Inspect skin for signs of breakdown especially over bony prominences, and under breasts, abdominal folds, axilla areas, heels, ankles • Remove socks or support hose daily to inspect feet for signs of pressure or skin breakdown	1. Cleanse with Aloe Touch Personal Cleansing Wipe. Dry area thoroughly 2. Apply Remedy Phytoplex Hydraguard to protect intact skin after cleansing and reapply as needed 3. Inspect skin with each cleansing to identify early breakdown.	1. Cleanse with *Aloe Touch Personal Cleansing Wipe*. Dry area thoroughly 2. Apply *Remedy Phytoplex Z-Guard* to protect compromised skin after cleansing. • Apply skin protectant to denuded or macerated skin • Utilize a thin layer, and cleanse soiled area only until clean. It is not necessary to remove all of the skin protectant. • Inspect skin with each cleansing	1. Cleanse with *Aloe touch Personal Cleansing Wipe*. Dry area thoroughly 2. Apply *Remedy Phytoplex Z-Guard* to protect wet, weepy, draining areas of the legs • Avoid putting skin protectant in between the toes	1. Cleanse with *Aloe Touch Personal Cleansing Wipe*. Dry area thoroughly. 2. Apply Remedy *Phytoplex Z-Guard* to denuded or macerated skin. • Implement measured to prevent friction and moisture in skin folds • May also need anti-fungal treatment	1. Cleanse with *Aloe Touch Personal Cleansing Wipe*. Dry area thoroughly 2. Apply Remedy Phytoplex Anti-fungal Clear to affected area and reapply twice daily. • Consider treating fungal rash for 14 consecutive days, even if rash improves.

3 of 3