STANDARD WOUND CARE PROTOCOL

BRUISES
- Measure the bruise and document in the nurses note, identifying the cause and treatment plan. Fill out an incident report and leave it for the RN.
- If the area is intact, leave it open to air and protect it i.e. long sleeves or geri gloves.
- If the area is open follow the protocol for skin tears that follows.

BLISTERS
- Measure the area and make a nurses note as to the cause and treatment initiated. Fill out an occurrence report and leave it for the RN.
- Never pop an intact blister. If we can protect the area and prevent it from opening we can frequently heal them up in a short amount of time.
- To protect a blister, use heel protectors, or long sleeves depending on location. Allevyn may be used to cover and protect a blister and help is reabsorb.
- Never apply any adhesive material to the surface of a blister.
- If a blister opens follow the guidelines below for the stage at which the open area is, frequently this will be stage two or three.

SKIN TEAR WITH INTACT SKIN FLAP
- Make a nurses note as to the cause of the skin tear and the treatment initiated and fill out an incident report.
- If the skin tear has a skin flap present it should be re-approximated, steri stripped and covered with gauze and cover roll. Do not use telfa as the wound will heal faster if it can breath. Only change the dressing if it becomes soiled. After one week remove the outer dressing and leave the steri strips intact until they fall off on there own.
- If a skin flap is present but dry, soak the area with wound cleanser until it can be re-approximated. Then proceed with the procedure above. If there is no way to re-approximate the skin flap follow the procedure outlined for skin tears with no skin flap.

SKIN TEAR WITH NO SKIN FLAP PRESENT
- Make a nurses note as to the cause of the skin tear and the treatment initiated and fill out an incident report and leave it for the RN.
- If the skin tear does not have a skin flap that can be re-approximated it should be cleansed and covered with a dressing following these guidelines:
  1. If there is no drainage the wound bed is dry or has minimal drainage use FlexiGel dressing and change every three days and PRN.
  2. If the wound is moister with moderate to heavy drainage use Allevyn again change every three days and PRN.

STAGE ONE PRESSURE ULCER
- Assess the cause of the redden area and take steps to eliminate that cause.
- Make a nurses note as to the description of the area and fill out an occurrence report and leave it for the RN.
- If due to incontinence apply EPC cream with each attends change. Limit the amount of time the resident spends in a position that will increase the pressure to that area.
• Ensure that a regular repositioning plan is in place for the resident.

STAGE TWO PRESSURE AREA
• Assess the cause of the breakdown and take steps to eliminate that cause.
• Make a nurses note as to the description of the area and the treatment initiated and fill out an occurrence report and leave it for the RN.
• If the area is dry or has minimal drainage cover the area with FlexiGel. Change the dressing every three days and PRN.
• If the area has moderate to heavy drainage cover with Allevyn and change it every three days and PRN.

STAGE THREE PRESSURE AREAS
• If the wound bed has granulation present and minimal drainage apply Solosite Gel or Intrasite Gel, cover with op-site or CovRSite. This should be changed daily.
• If the wound bed has granulation with moderate drainage cover with Allevyn and change it every three days, sooner if drainage comes through the dressing.
• If the wound bed has granulation and heavy drainage cover with AlgiSiteM and cover with CovRSite, this should be changed daily.
• If there is sloughing or necrotic tissue and the drainage is minimal, cover with SoloSite gel or IntraSite Gel and cover with CovRSite, this should be changed daily.
• If there is sloughing or necrotic tissue and the drainage is moderate to heavy, cover with AlgiSiteM and cover with CovRSite and change it daily.

STAGE FOUR PRESSURE AREAS
• If the wound bed has granulation tissue present and minimal drainage, cover with SoloSite Gel or IntraSite Gel cover with CovRSite, change it daily or cover with Allevyn Adhesive and change it every 2-3 days.
• If the wound bed has granulation tissue and moderate to heavy drainage cover with AlgiSite M pad or Rope cover with CovRSite, change daily or use Allevyn adhesive and change it every 2-3 days.
• If the wound bed has sloughing or necrotic tissue and minimal drainage use either SoloSite or IntraSite Gel covered with CovRSite and change it daily or Allevyn Adhesive changed every2-3 days.
• If the wound bed has sloughing or necrotic tissue with moderate to heavy drainage use either AlgiSiteM Rope or Pad covered with CovRSite changed daily or Allevyn Adhesive changed every 2-3 days.

NOTE:
• The RN should be notified of any changes in a resident’s skin condition no matter if you think it is serious or not.
• The RN may make treatment recommendations that may differ from the above guidelines based on experience or new treatments available.
• If you ever have any questions or concerns about a wound notify the RN immediately.
• When charting on a wound chart only the facts, do not make assumptions or diagnosis.