LOS ANGELES GENERAL MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

Subject:	Original Issue Date:	Policy #
PRESSURE INJURY PREVENTION & WOUND MANAGEMENT	09/08	**805**
	Supersedes: 4/22	Effective Date: 02/24

Departments Consulted:	Reviewed & Approved by:	Approved by:
Wound Care	Professional Practice Committee Nurse Executive Council Attending Staff Association Executive Committee	(signature on file) Nancy Blake Chief Nursing Officer

PURPOSE

This policy and procedure establish guidelines for the assessment of risk, early detection, prevention, and identification of occurrence of skin breakdown in hospital patients. It also describes interventions, management and documentation of potential or actual cases of alteration in skin integrity during the patient's hospital stay.

POLICY

Los Angeles General Medical Center is committed to providing quality care to all its patients. Risk for pressure injury development will be evaluated upon admission to a nursing care unit as indicated using the age appropriate Braden scale, appropriate tool, or procedure. Based on assessment, a plan of care will be developed and implemented using appropriate prevention and treatment interventions (see appendices). The primary care provider shall be informed of patient skin integrity issues and documented in the patient's medical record.

PROCEDURE

1. **Assessment/Reassessment**:
   a. Use age appropriate Braden Scale on all inpatients, to assess for pressure injury risk (refer to Appendix A):
      - Utilize Braden Scale for patients greater than 8 years old
      - Braden Q scale for patients 21 days old up to 8 years old.
        -On admission
        -Daily
        -Transfers
        -PRN (e.g., Decline in patient condition)
        -After prolonged procedure/ surgery (longer than 2 hours)

   b. Skin assessment, on ALL patients, which includes a head-to-toe physical inspection of the skin.
      - Frequency Minimum (May do more frequently based on patient condition)
        - Every 4-hours (ICUs)
          - Adult
          - Pediatric
          - Neonatal

- Every shift (Level 1 & 2 Nursery/Rooming-in/Ward/Progressive Care)
  - Adult
  - Pediatric
  - Newborn/Infant
- Daily (Behavior Health)

- On Admission and Transfer, "Four Eyes" with 2 licensed professionals" (Two RNs or One RN/One provider)
- Preventive/Protective padding placed over intact, non-broken skin are temporarily removed when performing a skin inspection.
- Therapeutic/Immobilization devices, e.g. cervical collars, trach collar, boots, braces, halo vests, and thoracic lumbosacral orthoses (TLSOs), may require a physician's order prior to removal. The device is still to be checked for tightness around skin and bony prominences, moisture, surrounding skin status, and patient comfort.
- Return from prolonged procedures/surgeries
- When there is a decline in patient's condition
- Per primary care provider order

2. Plan of Care:
RNs initiate Interdisciplinary Plan of Care (IPOC), related to skin integrity, for patients with actual or at risk for (Braden Score of 16 or less) impaired skin integrity. Licensed vocational nurses, nursing attendants, and student nurse workers are to collaborate with the RN ensuring the plan of care compliments the patient's needs and interventions are carried out.

3. PRESSURE INJURY PREVENTION INTERVENTIONS:
a. Braden Scale for predicting Pressure risk (Appendix A)
b. DHS: SSKIN-MED Pressure Injury Prevention Bundle (Appendix B)
c. DHS Heel Offloading Criteria (Appendix C)
d. DHS Pressure Redistributing Cushion Criteria: WAFFLE cushion usage (Appendix D)
e. DHS Bed Criteria: WAFFLE® Overlay Usage (Appendix E)
f. DHS Bed Criteria: WAFFLE® Overlay ED Usage (Appendix F)
g. DHS Bed Criteria: Facility Owned (Appendix G)
h. DHS Bed Criteria: Rentals (Appendix H)

4. Treatment/Equipment Interventions
a. Treat the underlying wound etiology
b. Wounds- start initial treatment based on the DHS facility Wide Wound Care Quick Reference Guide (Appendix I)
c. When "Do not turn" orders are in place:
   - Reassess the patients stability to be turned, if patient tolerates, notify the provider to discontinue "Do not turn" order.
d. Refer to DHS Pressure redistributing Cushion Criteria: WAFFLE cushion usage (Appendix D)

e. Refer to DHS Bed Criteria: WAFFLE® Overlay (Appendix E)
f. Refer to DHS Bed Criteria: WAFFLE® Overlay ED usage (Appendix F)
g. Refer to DHS Bed Criteria: Facility Owned (Appendix G)
h. Refer to DHS Bed Criteria: Rentals (Appendix H)

5. PHOTOS

a. On admission when admitted with skin impairment, upon discovery of a new skin impairment, when significant changes occur and within a week of discharge or transfer to outside facility. Photograph must include medical record number, date and time.

6. NOTIFICATIONS

a. Primary Care Provider (Not Limited To):
- Wound/Skin abnormalities present on admission and upon discovery
- Deterioration of existing wound/skin abnormality
- Need for possible debridement
- Signs of infection
- Orders for wound treatment

7. CONSULTS

a. Wound Nurse (WN) for Community Acquired Pressure Injuries (CAPI)
- Stage 2 and Deep Tissue Pressure Injuries (DTPI)

b. WN for Hospital Acquired Pressure Injuries (HAPI)
- Stage 2 and Above

8. COLLABORATE

- With providers for interdisciplinary consults, as appropriate.

9. DOCUMENTATION

a. In accordance with “Documentation” standards
b. Interdisciplinary Plan of Care (IPOC)
c. All pertinent information related to skin abnormalities
d. Pressure injury prevention interventions
e. Bed Type/Surface
f. Photos taken
g. Provider that was notified
h. Patient/Care Giver/Family Education

10. ATTACHMENTS

DHS PIP & Wound Management Algorithm (Attachment I)
Braden Scale for Predicting Pressure Sore Risk © (Appendix A)
DHS: SSKIN-MED Pressure Injury Prevention Bundle (Appendix B)

DHS Heel Offloading Criteria (Appendix C)
DHS Pressure Redistribution Cushion Criteria: WAFFLE® Cushion Usage (Appendix D)
DHS Bed Criteria: WAFFLE® Overlay Usage (Appendix E)
DHS Bed Criteria: WAFFLE® Overlay ED Usage (Appendix F)
DHS Bed Criteria: Facility Owned (Appendix G)
DHS Bed Criteria: Rentals (Appendix H)
DHS Facility Wide Wound Care Quick Reference Guide (Appendix I)

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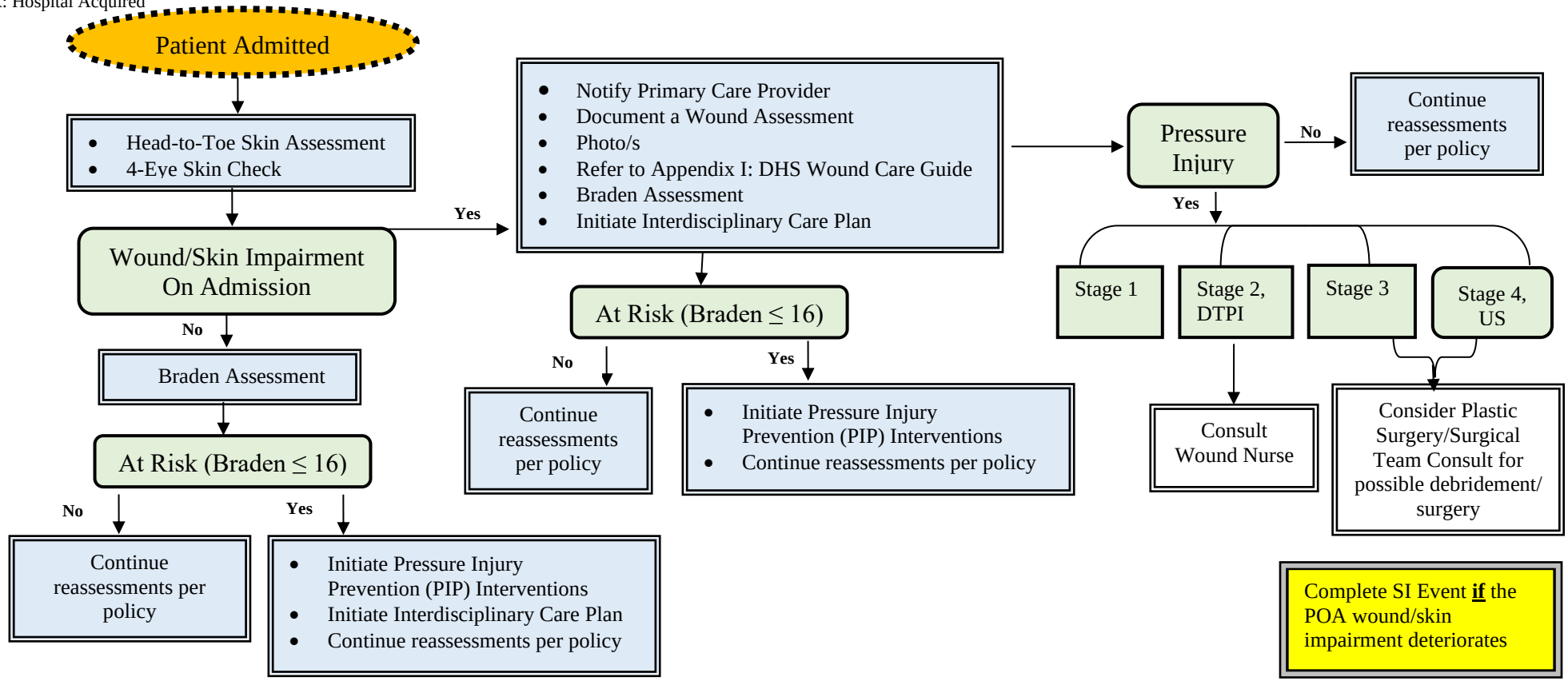
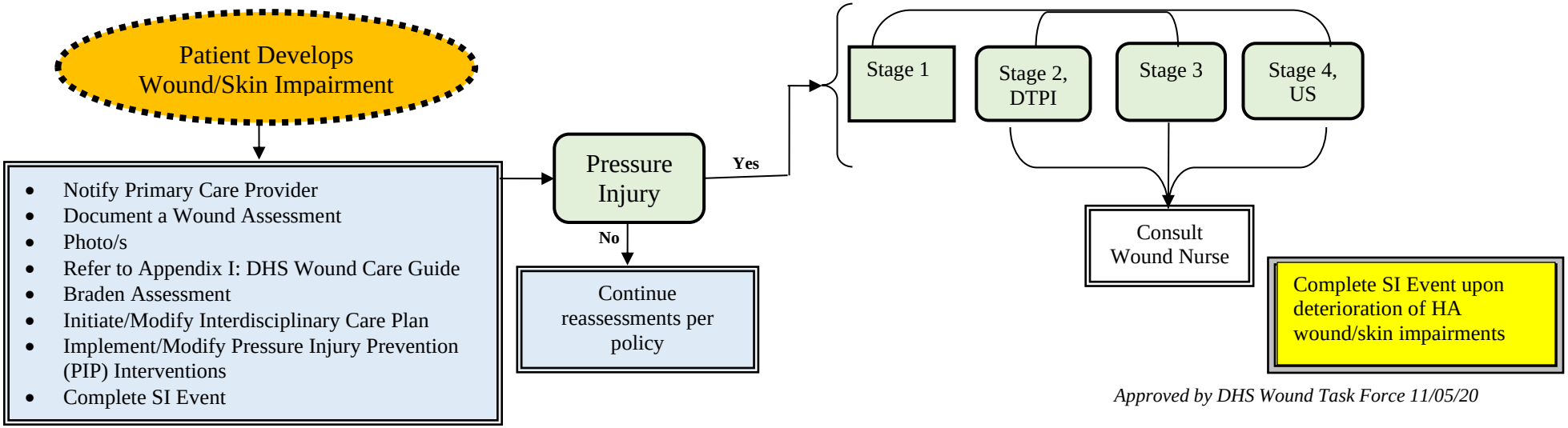
REVISION3
9/10, 01/14, 01/17, 11/17, 4/22, 02/24

Safety Intelligence™ (SI) Event Report
DTPI: Deep Tissue Pressure Injury
US: Unstageable
POA: Present on Admission
HA: Hospital Acquired

DHS Pressure Injury Prevention & Wound Management Algorithm





Approved by DHS Wound Task Force 11/05/20

Appendix A

Braden Scale for Predicting Pressure Sore Risk

Sensory perception Ability to respond meaningfully to pressure-related discomfort	**1. Completely limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface.	**2. Very limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly limited:** Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Moist:** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. Occasionally moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely moist:** Skin is usually dry; linen requires changing only at routine intervals.
Activity Degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	**3. Walks occasionally:** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Mobility Ability to change and control body position	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern	**1. Very poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. Probably inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and shear	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No apparent problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	
Total Score:				

Reference: Los Angeles County – Department of Health Services was granted permission to use the "Braden Scale for Predicting Pressure Sore Risk" tool manually and electronically February 2019.

Appendix B

DHS: SSKIN-MED Pressure Injury Prevention Bundle

S - Skin Inspection and Risk Assessment (Braden)

- Perform a thorough head-to-toe skin inspection.
  - Check skin under hair, on bony prominences and under medical devices.
  - Use proper lighting.
  - Separate skin folds.
  - Palpate for moisture and induration.
- Perform risk assessment scale (Braden) to identify risk fact.

S – Support Surfaces

- Include mattresses, wheelchair cushions and any therapeutic surfaces.
- Minimize layers of linen under patient – <u>less is best!</u>

K - Keep Moving/Turning

- Turn/reposition every 2 hours while in bed, gurneys, etc.
- For independent patients, encourage them to perform pressure relief every 15 to 20 minutes when in chair. For dependent patients, assist them to perform pressure relief every hour for 2 full minutes.
- Offload bony prominences or pressure areas (e.g. heels, sacrum-coccyx).
- Attempt micro shifts for patients with “Do Not Turn” order as condition allows.

I – Incontinent and Moisture Management

- Keep skin clean and protected from stool, urine, and wound drainage.
- Apply skin barrier creams/paste/film to incontinent patients.
- Keep skin moisturized to avoid very dry skin.
- Do NOT use diapers when patient is in bed.

N – Nutrition and Hydration

- Encourage and monitor food and fluid intake: protein, supplements, and water.
- Consult dietician as needed

M – Medical Devices and Devices

- Check for tightness under straps.
- Stabilize tubes/devices.
- Pad under devices.
- Assess skin under and around medical devices every shift (Remove devices to assess if appropriate).
- Ensure correct fit/size.
- Question use of device and if still medically needed.
- Ensure skin is in optimal condition (e.g. moisturized).

E – Educate Patient and Caregiver

- Provide teaching and hands-on materials to both patient and caregivers.

D – Documentation

- Assessments, individualized interventions, patient non-adherence and patient/caregiver response to be documented in electronic health record (EHR) and plan of care as appropriate.

Appendix C

DHS Heel Offloading Criteria

If Patient NOT able to lift foot AND

Presents with one of the following:

- At risk for foot drop
- Mild to moderate foot drop
- On vasopressors (hemodynamically unstable)
- Current pressure injuries on heel

Use TruVue® Boot

SIZES		
Petite	**Standard**	**X-Large**
Calf measures 7”-12.5” TRUVUEPW060	Calf measures 13”-18” TRUVUESW060	Calf measures 18.5”-25.5” TRUVUEXL060

- **Remove TruVue® boot for skin inspection every shift.**
- **Discontinue when no longer medically needed.**

If Patient ABLE to lift foot OR

Presents with one of the following:

- Lower extremity contracture/s
- Severe foot drop
- Severe spasticity
- Peripheral Vascular Disease

Use Pillow

04/29/20

Appendix D

DHS Pressure Redistribution Cushion Criteria

WAFFLE® Cushion Usage

Use to Provide Comfort, Prevention and Healing of Pressure Injuries in **At-Risk** Patients

Single patient use

Some Indications for Use

- **At Risk** patients or a history of pressure injury (PI) on sacrum, coccyx or ischial tuberosities
- Prevention of pressure injuries and comfort for seated patients
- For patients during chemotherapy, hemodialysis or other procedures requiring patients to sit for prolonged periods of time
- For patients with but not limited to: Post perineal, Gynecological, Colorectal and Urological surgeries
- Behind the back of patients with spinal abnormalities (e.g. kyphosis, cachexia)
- Can be used for prevention and healing of all pressure injuries and wounds in various locations (e.g. behind head, elbows)

WAFFLE® Cushion, 2200WCI:
Weight capacity: 300 lbs.
Flame retardant.
Antimicrobial/Antifungal

WAFFLE® Bariatric Cushion, 2400WCV:
Weight capacity: 700 lbs.
Flame retardant • Antimicrobial/Antifungal

Sitting Precautions

Patient should shift or lift their body weight every 15-20 minutes; however, patients should not sit longer than 2 hour intervals

Proper Inflation

Before use test for accurate inflation: roll the cushion past the first set of holes, stopping before the second set of holes.

Cushions should appear to be 60% full

Cushions come pre-inflated and can be wiped clean with approved facility germicidals.

Cover the cushion with a pillowcase for added patient comfort. Label cushion with patient's name.

Cushions should stay with the patient throughout the hospital and be sent home upon discharge. At home patient may clean with soap and water.

Alternate Uses

For Rancho Spinal Cord Injuries (SCI): Follow SCI wheelchair sitting program

Reference: "Clinical Guidelines for Use of WAFFLE® Seat Cushion Protection Beyond the Chair", EHOB 2019.

02/07/19;
Revised: 06/10//20

Appendix E

DHS Bed Criteria

WAFFLE® Overlay Usage

Use to Provide Comfort, Prevention and Healing of Pressure Injuries in **At-Risk** Patients

Some Indications for Use

- Pressure injuries of any stage
- Complex wounds
- Unable to reposition self due to cognitive or physical impairment
- Elderly/Frail
- Hemodynamically unstable
- Multisystem trauma
- Cachexia or Obesity
- Intractable pain
- **Stable Spinal Cord Injury / Fracture**

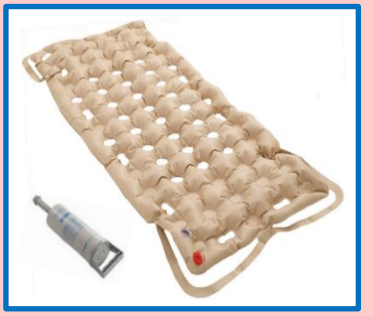
Considerations

- Can be used for safe patient handling and transfers
- Can be used during CT Scans, MRIs and is radiolucent for X-ray
- Can be placed on most surfaces (e.g. beds, gurneys, OR tables)

Proper Inflation

Place patient on noninflated overlay then add air and perform a hand check. Perform a hand check each shift and after every adjustment of air to check for over inflation or "bottoming out". Place hand, palm side up, under overlay. Use fingers to tap upward to feel approximately ¼ inch air inflated within the cushion directly under the patient's sacrum/tailbone.

Single patient use



WAFFLE® Overlay, 1005ECP:
Weight capacity: 600 lbs.

WAFFLE® Overlay, 1076BMPX020:
Weight capacity: 800 lbs.

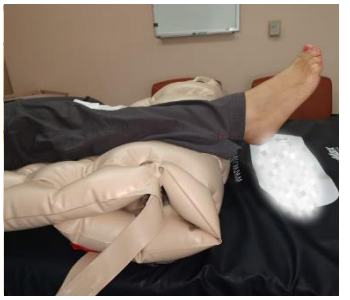
Antimicrobial ● Antifungal ● Flame Retardant

Single patient use:

- Label overlay and pump with patient's name
- Both overlay and pump should stay with the patient throughout the hospital and be sent home upon discharge

Cleaning:

- Can be cleaned with any hospital germicidal wipes
- Operating Room/Special Procedures: if heavily soiled with body fluids after initial cleaning, discard and replace
- At home patient may clean with soap and water



04/30/20

Contraindications: Do not use for patients with unstable spines

Appendix F

DHS Bed Criteria
Department of Emergency Management

WAFFLE® Overlay Usage

Use to Provide Comfort, Prevention and Healing of Pressure Injuries in **At-Risk** Patients

Patient Waiting in the DEM

Less Than 2 Hours

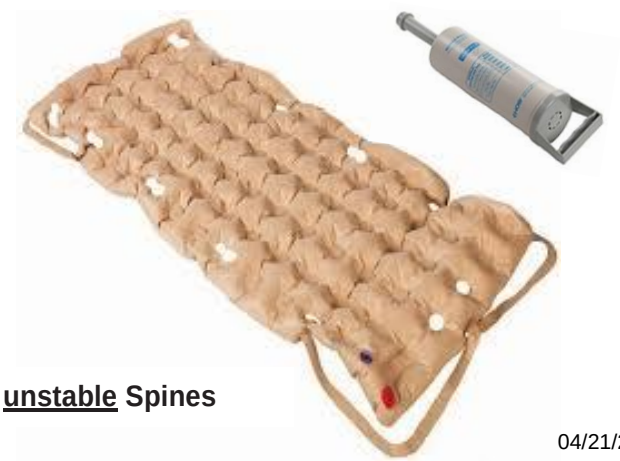
WAFFLE® Not Required

More Than 2 Hours

Does the patient have one of the following criteria?

- **Pressure injury of any stage**
- **Unable to reposition due to cognitive or physical impairment**
- **<u>Stable</u> spinal cord injury / Fractures**
- **Came in with one of the following:**
  - ✓ **Elderly/Frail/Malnourished**
  - ✓ **Unresponsive**
  - ✓ **Unable to breathe without assistance**
  - ✓ **Found down**
  - ✓ **Hemodynamic instability**
  - ✓ **Multisystem trauma**
  - ✓ **Dehydration**
  - ✓ **Decreased pain awareness**
  - ✓ **Obesity/Cachexia**

Place patient on a WAFFLE® Overlay



Considerations:

- Can be used for safe patient handling and transfers
- Can be used during CT Scans, MRIs and is radiolucent for X-ray
- Can be placed on most surfaces (e.g. beds, gurneys, OR tables)

Proper Inflation:

- Perform a hand check each shift and after every adjustment of air. To check for "bottoming out", place hand palm side up, under overlay beneath patient's sacrum/tailbone. Use fingers to tap upward to feel approximately ¼ inch air inflated within the cushion directly under the patient's sacrum/tailbone

Single patient use:

- Label overlay and pump with patient's name
- Both overlay and pump should stay with the patient throughout the hospital and be sent home upon discharge. At home patient may clean with soap and water.

Cleaning:

- Can be cleaned with any hospital germicidal wipes
- Operating Room/Special Procedures: if heavily soiled with body fluids after initial cleaning, discard and replace

Contraindications: Do not use for patients with <u>unstable</u> Spines

04/21/20

Appendix G

DHS BED CRITERIA: **(Facility Owned)**

- **If beds owned by the facility are being used in conjunction with WAFFLE ® Overlay and are still not meeting patient goals, refer to "DHS Bed Criteria: (Rentals)" Appendix H.**
- **For patients with unstable spine/fractures follow facility protocols.**

Pressure Redistribution

AccuMax
(500lbs max)

Centrella Pro
(500lbs max)

Criteria For Use

- Non-powered mattresses
- Prevention of pressure injuries
- Treatment of Stage 1-2 (on extremities)
- Non-complex and conservative pressure injury management

ADD

WAFFLE ® Mattress Overlay

- Prevention for increased risk
- Treatment of multiple Stage 1-4, DTPI, & unstageable on torso (e.g. back, trochanter, sacrococcyx)
- Elderly, cachectic, malnourished, frail
- Unable to self-turn
- HOB consistently greater than 30 degrees
- **STABLE** spinal injury / fractures

Pressure Redistribution & Advanced Microclimate

P500
(Max Length: 84")

Centrella MAX
(Max Length: 98.7")

TotalCare Sport
(Max Length: 93")

Progressa
(Max Length: 88")

Criteria For Use

- Low air loss integrated mattresses
- May be used on high risk patients
- Used for single/multiple Stage 3-4
- Excessive unresolved perspiration/incontinence issues
- Total Care Sport & Progressa have pulmonary features
- Progressa are used primarily in ICU and may also be used in other units as directed by each hospital protocol
- Maximum weight of 500 pounds

ADD

WAFFLE ® Mattress Overlay

- When mattress is not meeting patient goals
- Treatment multiple Stage 1-4, DTPI, & unstageable.
- HOB consistently greater than 30 degrees
- Multisystem Trauma
- **STABLE** spinal injury / fractures

Bariatric Pressure Redistribution & Advanced Microclimate

TotalCare Bariatric
(500lbs max)

Compella
(1000lbs max)

Criteria For Use

- Obese or wide girth
- TotalCare Bariatric (Width expands to 40")
- Compella (Width expands to 50")

ADD

WAFFLE ® Bariatric Mattress Overlay

- When mattress is not meeting patient goals
- 800 lbs. max
- **STABLE** spinal injury / fractures

3/11/20

DHS BED CRITERIA: **(Rentals)**

Rent one of these: **If facility owned bed with WAFFLE ® Overlay is not meeting patient goals.**

Pressure Redistribution & Advanced Microclimate

Envision
(400 lbs max)

Criteria For Use

- Mattress fits VersaCare and flat deck bed frames
- Treatment of multiple/complex stage 3 & 4, extensive Unstageable and DTPI

Envella
Air Fluidized Therapy
(350 lbs max)

Criteria For Use

- Extensive Stage 3, 4, Unstageable and DTPIs
- Immediate post flap/grafts of major turning surface
- Very contracted with intractable pain
- Burns management by BURN Unit physician criteria
- Max length 74”

Bariatric
Pressure Redistribution & Advanced Microclimate

TotalCare Bariatric
(500 lbs max)

Criteria For Use

- Prevention & treatment of pressure injuries
- Turn assist
- **Full Chair position**
- Continuous Lateral Rotation Therapy (CLRT) & Trapeze (optional when ordering)
- Adjustable length to 72-84”
- Width expands to 40”

Compella Bariatric
(1000 lbs max)

Criteria For Use

- Prevention & treatment of pressure injuries
- Turn assist
- Continuous Lateral Rotation Therapy (CLRT) & Trapeze (optional when ordering)
- Adjustable length to 88”
- Width expands to 40-50”

Appendix I

DHS Facility Wide Wound Care Quick Reference Guide

Incontinence Assoc Dermatitis (IAD)	Fungal Dermatitis	Skin Tear	Intact Skin	Partial Thickness Wounds		Full Thickness Wounds			Deep Tissue Pressure Injuries (DTPI)
			Stage 1 Pressure Injury 	Stage 2 Pressure Injury 	Bulla (Serous Blister) 	Stage 3 Pressure Injury 	Stage 4 Pressure Injury 	Unstageable Pressure Injury 	

Treatment Objectives: If it's wet, absorb it. If it's dry, moisten it but protect the wound.

Protect Treat cause Turn schedule	Protect Treat cause Separate skin folds	Protect Treat cause Maintain drainage	Offload pressure Turn schedule Moisturize skin	Offload pressure Manage drainage Turn schedule	Offload pressure Manage drainage Turn schedule	Offload pressure Manage drainage Turn schedule	Offload pressure Protect Turn schedule

Topical Treatments & Dressing Change Frequency

Intact or Non-Intact	Intact or Non-Intact	Tear with Flap	Dry Skin	Light Drainage	Intact Blister	Wound Drainage	Unstageable Pressure Injury	Intact Blood Blister
Apply a protective skin barrier when incontinence first identified. Gently cleanse and apply protective skin barrier every episode Examples: • Calazime • Nutrashield • Calmoseptine • Cavilon • Clear Aide • Touchless Care Zinc Oxide • A&D ointment	Cleanse the skin prior to each application. Apply antifungal cream, ointment or antifungal powder BID and PRN. Requires **provider's** order **Separate skin folds to decrease moisture** Decrease skin to skin contact with a barrier such as non-adherent or soft woven gauze.	Approximate flap, cover with a contact layer then cover with secondary dressing Change daily and PRN. Contact Layers: • Adaptic • Xeroform • Vaseline **Tear Without Flap** Cover with: • Foam if drainage Change q 3 days and PRN. • Transparent film if no drainage & non-fragile skin. Allow to fall off naturally If fragile skin use contact layer with secondary dressing.	Apply moisturizing cream daily and PRN Examples: • Remedy Skin Cream **Moist Skin** Apply protective skin barrier PRN **Friction Areas** Apply barrier film daily and PRN. Examples: • Cavilon **Or** Apply transparent film to non-fragile skin q 3 days and PRN **Device Related erythema** Apply barrier film and protective padding daily and PRN	Apply hydrocolloid or foam. Change q 3 days and PRN Hydrocolloids: • RepliCare • CombiDERM • Duoderm • Restore • 3M Tegaderm • Nu-Derm **Moderate-Heavy Drainage** Apply non-adhesive or adhesive foam. Change q 3 days and PRN **Areas Exposed to Stool/Urine** (Intact & Non-Intact) Apply protective skin barrier every episode.	Apply Cavilon barrier film daily and leave open to air **or** Apply a Contact Layer (unfold to a single layer and cut to size) cover with gauze. Change daily & PRN **Drainage** Apply contact layer with secondary dressing. Change daily and PRN.	**None – Minimal Drainage** Apply hydrogel and contact layer then cover with gauze. If cavity is present, impregnate filler (e.g. gauze roll, packing strip) with the hydrogel. Change daily and PRN. Examples: • SoloSite • IntraSite • NuGel **Moderate – Heavy Drainage** Apply calcium alginate and cover with foam (q3 days & PRN) or gauze/ABD pad (daily & PRN). If cavity is present and filler is needed select appropriate calcium alginate form (e.g. rope, roll, ribbon). Calcium Alginate examples: • Algisite M • KaltoSTAT • 3M Tegaderm • Nu-Derm	**Stable Eschar (non-infected)** Apply Cavilon barrier film daily and leave open to air • **Do Not** Remove eschar • **Do Not** moisten • **Do Not** apply foam **Unstable Eschar/Slough (non-infected)** Apply transparent film (q3 days) or Hydrogel covered with gauze dressing (daily & PRN **Consult Primary Provider**: For consideration of sharp debridement if indicated	Apply Cavilon barrier film daily and leave open to air **or** Apply a Contact Layer (unfold to a single layer and cut to size) cover with gauze. Change daily & PRN **Intact Skin (over dry areas)** Apply moisturizing cream daily & PRN **Intact or Non-Intact Skin** Apply Cavilon barrier film daily and leave open to air **Areas Exposed to Stool/Urine** (Intact & Non-Intact) Apply protective skin barrier every episode.

Assess	**Braden scores & need for specialty bed per protocol. Assess for signs and symptoms of wound infection, if identified notify primary provider. Inspect integrity of dressing to verify that the wound has not been exposed to stool or urine.**
Perform	**Cleanse all wounds before application of new dressings/treatments. Label dressings with the date and time applied.**
Please Note:	**This reference is to serve only as a guideline to assist in choosing the appropriate treatment/dressing. It is not all inclusive to the skin/wound care available. Clinics and Home Health wound care frequency may be different.** **Revised 1.23.20**

Reference: Use of wound care quick reference guide template with photos for policy with permission from Smith and Nephew, 2010. Deep tissue photo used for policy with permission from Medline, 12/2018.