GUIDELINE FOR: WOUND CARE
This guideline of care will be applied to any patient having stage II pressure ulcers and all full thickness wounds, and/or any patient whose MO 440 question is answered yes.

PURPOSE: To provide a guideline of practice by which Home Care agencies may consistently provide home management of open wounds

DISCIPLINE: Multidisciplinary - Each agency must define areas of responsibility.

<table>
<thead>
<tr>
<th>Patient Goals/Outcomes</th>
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<tr>
<td>Patient and/or primary caregiver verbalize/demonstrate:</td>
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<tr>
<td>1. Etiology of ulcer/wounds</td>
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<tr>
<td>2. Wound care procedure</td>
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<td>3. Adaptation of wound care related to healing</td>
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<td>4. Signs and symptoms of healing</td>
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<td>5. Effect of physical therapy on wound healing</td>
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<td>6. Signs and symptoms of infection</td>
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<td>7. Signs and symptoms of deterioration</td>
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<td>8. Appropriate nutrition related to wound healing</td>
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<td>9. Effect of personal habits on wound healing (hygiene, smoking, alcohol, drug use)</td>
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<td>10. Effect of medication on wound healing</td>
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<td>11. Importance of plan for medical follow through</td>
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<td>12. Ordering of wound care supplies</td>
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<td>13. Strategies for prevention of complication and/or reoccurrence</td>
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<td>14. Consequences of noncompliance with plan of care</td>
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<td>15. Disposal of soiled dressing</td>
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<td>16. Hand washing</td>
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Assessment Guideline:

1. A comprehensive assessment is completed on admission; and a minimum of every 60-day which may include OASIS question MO 440.
2. Assessments should include the following:
   A. History of wound/ulcer
      1. Onset of wound/ulcer
      2. Previous treatment and effectiveness
   B. Anatomical location of wound/ulcer
   C. Wound base, borders, exudate, odor, peri-wound tissue with each dressing change
   D. Measurement in centimeters weekly to include length, width, depth, undermining, tunneling (staging for pressures only).
   E. Presence or absence of edema in extremity if appropriate
   F. Vascular circulation to area of wound/ulcer
   G. Pain associated with wound care
   H. Reassess wound progress at least every two (2) weeks for decision to change or continue current therapy
   I. Additional health care problems
   J. Knowledge and compliance to medication regime
   K. Knowledge and compliance with nutritional requirements
   L. Patient and primary caregiver goals related to wound/ulcer care
   M. Impact of ulcer/wound on quality of life
   N. General sensory integrity
   O. Activity level and tolerance
   P. Support systems, psychosocial concerns and financial barriers
   Q. Home environment
**Intervention:**

Based on deficits found in the assessment, the plan must be comprehensive, patient specific, and may be multidisciplinary.

1. **Wound care performed using clean technique unless otherwise ordered**
   a. cleanse wound with tap water, saline, wound cleanser
   b. cover wound base with primary and secondary dressing, which provides for moist wound base.
   c. follow manufacturers instruction for product application
   d. twice daily and daily wound care should only occur if exudate cannot be contained or product manufacturer recommends that frequency
   e. edema must be controlled with lower extremity wound/ulcer
   f. debriding enzymes may be needed when necrotic tissue is in the wound base, in some circumstances autolytic debridement might be appropriate
   g. care of peri wound tissue

2. **Pain control measures**

3. **Collaborate with other disciplines and community resources as appropriate for nutrition, financial issues, supplies and other needs**

4. **Referral to Physical Therapy for exercise program, physical modalities and possible wound debridement**

5. **Referral to Occupational/Physical therapy for lymphedema assessment and treatment**

6. **Referral to Occupational Therapy for cognition evaluation, visual deficit, assistive devices for dexterity as appropriate**

7. **Teaching**
   a. etiology of wound/ulcer
   b. wound care procedure
   c. signs and symptoms of infection
   d. signs and symptoms of wound deterioration
   e. signs and symptoms to report to the physician
   f. symptoms requiring immediate attention
   g. adapting dressings to changing wound
   h. effect of other medical problems
   i. effect of medication on wound healing
   j. effect of nutrition on wound healing
   k. obtaining supplies
   l. benefits of physical activity
   m. effect of personal habits on wound healing
   n. prevention of reocurrence
      - pressure relief
      - positioning
      - skin care
      - control of edema
      - proper fitting shoes
   o. infection control measures
      - hand washing
      - use of gloves
      - disposal of waste/dressings

8. **Confer with physician about illness management**

9. **Instruct regarding self care between home care visits**
### Documentation
1. Wound care procedure
2. Wound measurements weekly
3. Wound description with each dressing change
4. Extremity edema when appropriate
5. Patient's tolerance of procedure
6. Effectiveness of pain control measures
7. Content of teaching
8. Patient and primary caregiver response to teaching
9. Patient or caregiver competency through return demonstrations as appropriate
10. Modifications to plan of care
11. Self care interventions between homecare visits
12. Communication with patient between homecare visits
13. Communication with physician
14. Communication with other disciplines involved

### Patient/Primary Caregiver Education:
Material should be produced in a manner that would allow for individualizing packets for each patient.
1. Etiology of wound/ulcer
2. Wound care procedure
3. Signs and symptoms of infection
4. Signs and symptoms of wound deterioration
5. Adapting dressings to changing wound
6. Effect of other medical problems
7. Effect of nutrition on wound healing
8. Effect of medication on wound healing
9. Obtaining supplies
10. Benefits of physical activity
11. Effect of personal habits on wound healing
12. Prevention of reoccurrence
   a. pressure relief
   b. positioning
   c. skin care
   d. control of edema
   e. proper fitting shoes
13. Infection control measures
   a. disposal of waste, soiled dressings
   b. hand washing
   c. use of gloves
Staff Education/Competence Outcomes:
Staff member will verbalize or demonstrate:
1. Wound assessment and documentation
2. Wound etiology
3. Physiology of wound healing
4. Use of wound care products to include:
   a. gauze primary dressing
   b. gauze secondary dressing
   c. hydrogel
   d. debriding enzymes
   e. foams
   f. films
   g. antimicrobial products
   h. skin substitutes
   i. compression dressings
5. Relationship of nutrition to wound healing
6. Impact of other medical problems
7. Impact of medications on wound healing
8. Elements of a physician’s order for wound care:
   a. frequency of wound care
   b. order to cleanse wound
   c. product for wound cleansing
   d. product applied to wound base and/or for packing wound
   e. use of cover dressing
   f. need to secure dressing
9. Signs and symptoms of acute wound infection
10. Signs and symptoms of chronic wound infection
11. Use of antibiotic or antimicrobial topical agents
12. Competency with advanced wound therapy as appropriate
   a. Negative Pressure Wound Therapy
   b. Oasis product application
   c. electrical stimulation
   d. ultrasound
   e. Warm Up Therapy
13. Assessment of referrals to other disciplines
14. Staff competent in Conservative Sharp Wound Debridement
15. How other disciplines can support, assist with, or perform wound/ulcer care
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Wisconsin Home Care Evidenced Based Practice Committee Contributors:
Cindy Fraker, RN, BSN, MSHA, Director, Divine Savior Home Care, Portage, WI
Cheryl P. Meyer, RN, BSN, Administrator, Marquardt Memorial Manor Home Health, Waterloo, WI
Terri Peterson, RN, BSN, MS, Vice President – Clinical Services, Home Health United, Inc., Madison, WI
Bobbie Spitz, APRN, CWS, Visiting Nurse Association of Wisconsin, Milwaukee, WI
Lisa White, RN, Director, Hillside Home Care & Hospice, Beaver Dam, WI