

Nursing Assessment and Management for Skin and Wound Care

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Note: This algorithm is intended for use by Wound Ostomy Care Nurses (WOCN) only

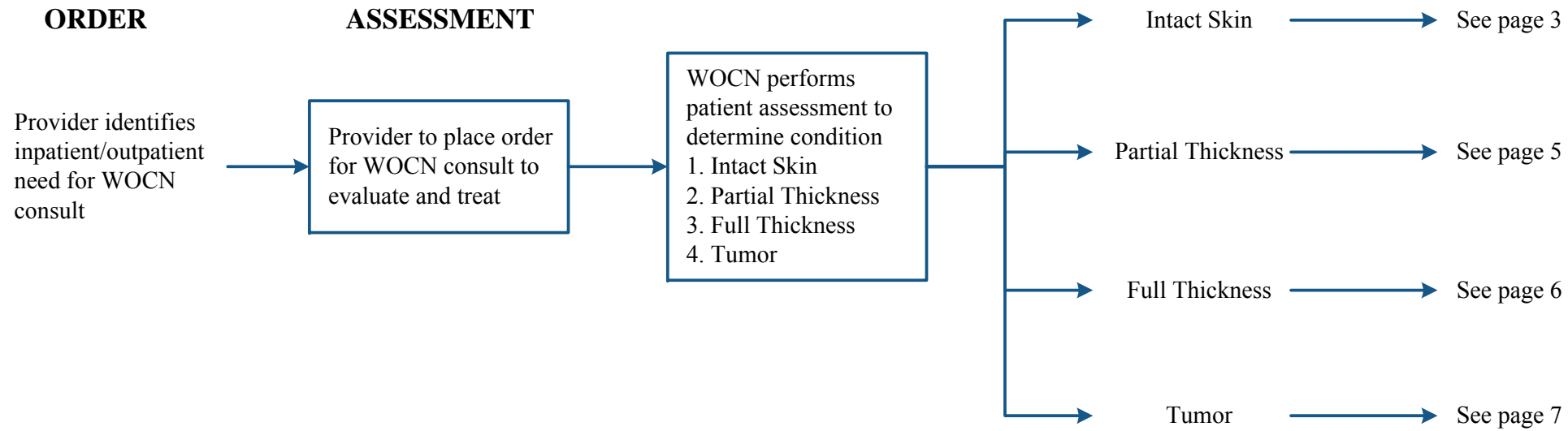
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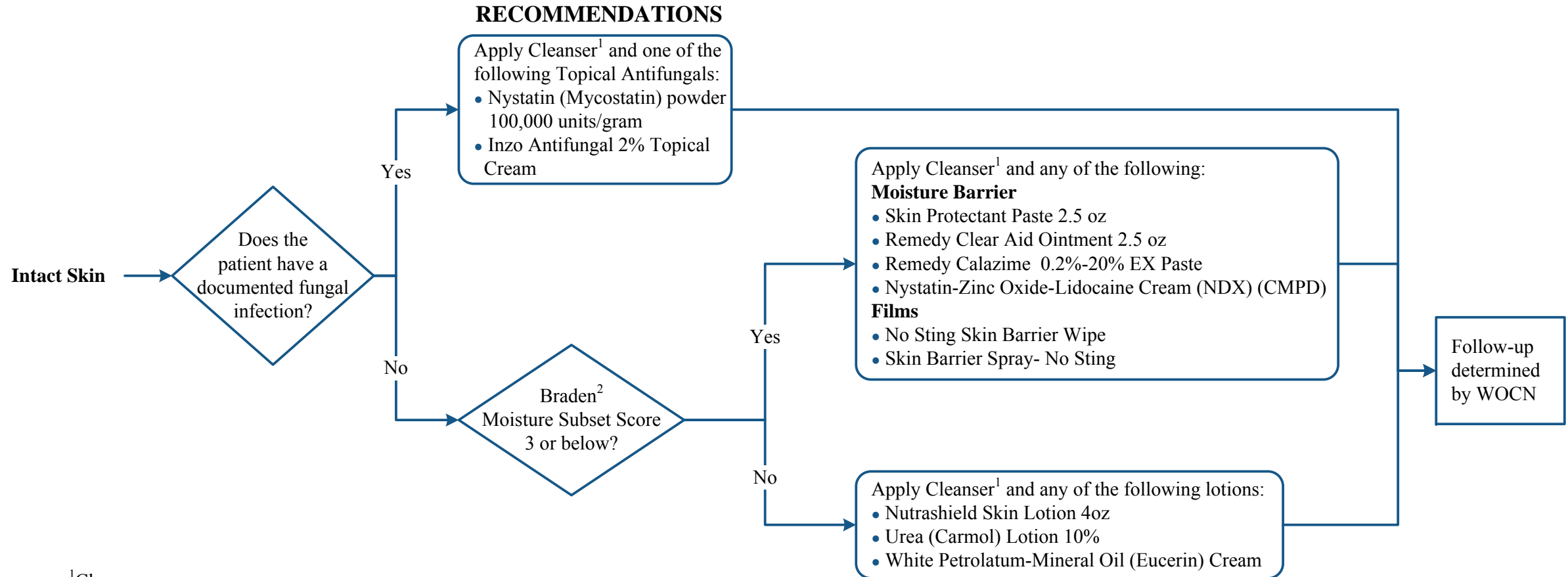
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¹Cleansers:

- Skin Cleanser: No Rinse Foam Cleanser 4n1 9oz
- Perineal Cleanser: Perineal Spray Cleanser 8oz
- Wipes: Fragrance-Free Flushable Perineal Wipes

²See Appendix A for Braden Scale

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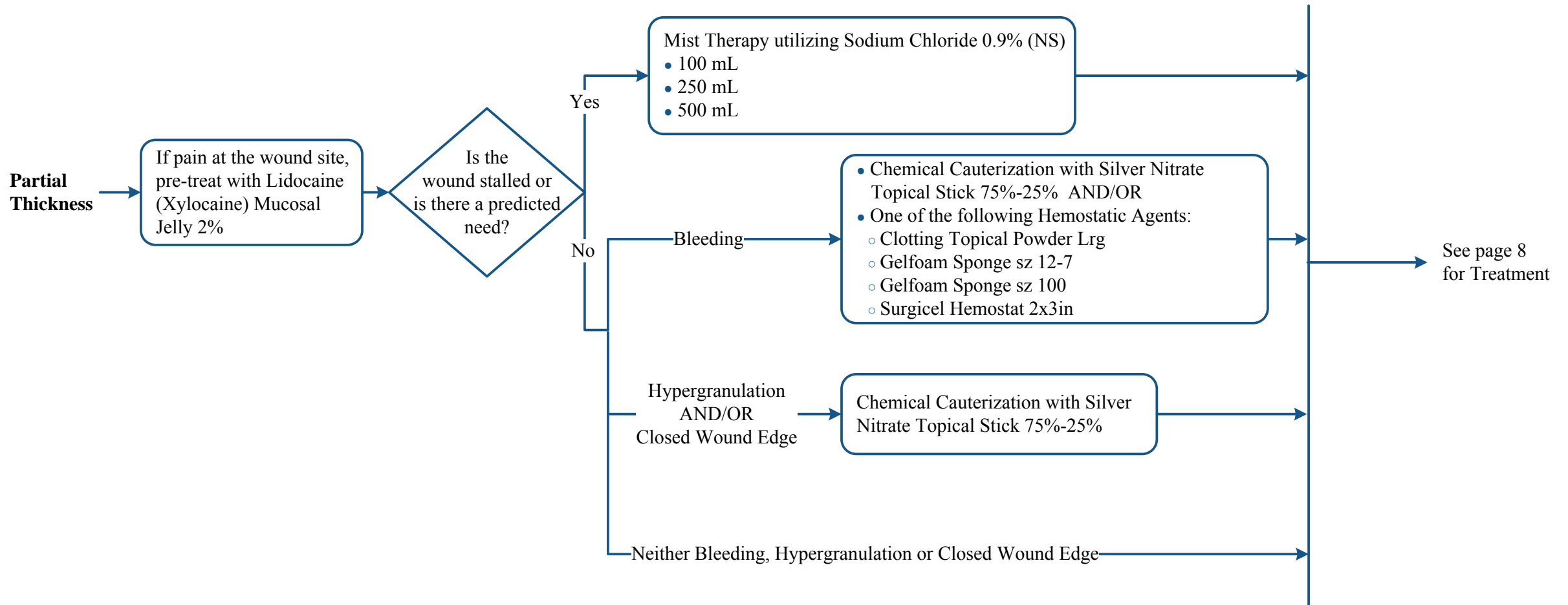
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APPENDIX A: Braden Scale

	1	2	3	4
Sensory Perceptions	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.	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 half of body.	Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture	Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Very Moist: Skin is often, but not always moist. Linen must be changed at least once a shift.	Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.	Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals.
Activity	Bedfast: Confined to bed.	Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks Frequently: Walks outside room at least twice a day and inside room at least once every two hours during waking hours.
Mobility	Completely Immobile: Does not make even slight changes in body or extremity position without assistance.	Very Limited: Makes occasional light changes in body or extremity position but unable to make frequent or significant changes independently.	Slightly Limited: Makes frequent though slight changes in body or extremity position independently.	No Limitation: Makes major and frequent changes in position without assistance.
Nutrition	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 and/or maintained on clear liquids or IVs for more than 5 days.	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.	Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day). Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	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	Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair. Spasticity, contractures or agitation leads to almost constant friction.	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.	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.	N/A

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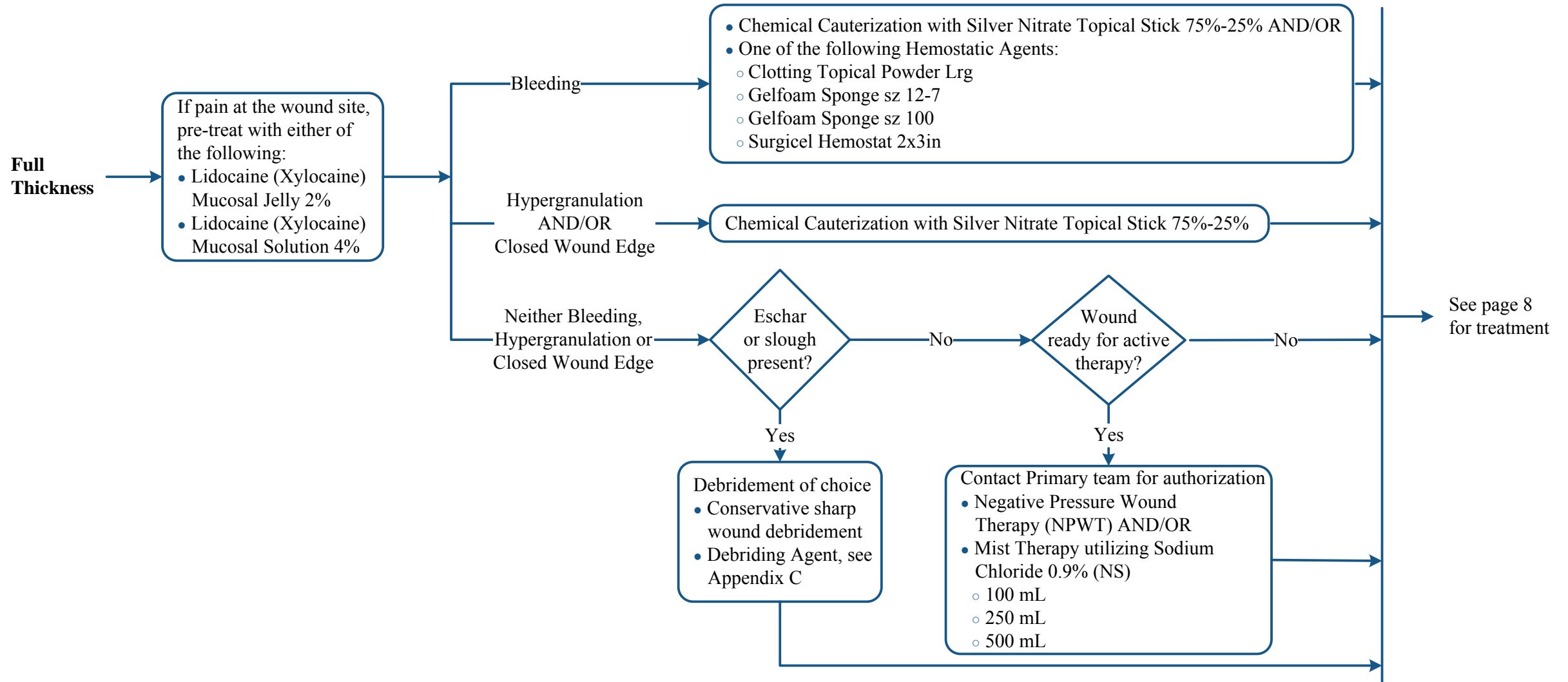
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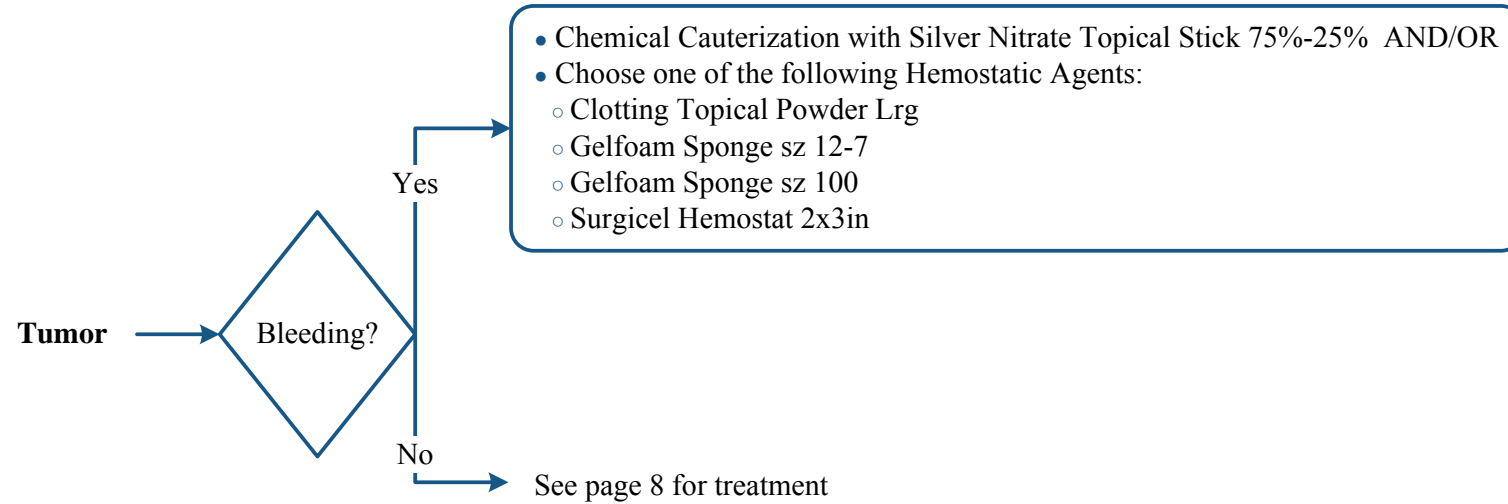
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TREATMENT (Full Thickness, Partial Thickness, and Tumor)



Appendix B: Cleanser of Choice

- **Wound Wash Saline 0.9% Ex Solution (Full and Partial Thickness Only)**
- **Antiseptics/Antimicrobials (All except Intact Skin)**
 - Chlorhexidine (Hibiclense) Topical Liquid 4%
 - Chlorhexidine Frepp Prep 1.5ml
 - Sodium Hypochlorite (Dakin's Quarter Strength) Topical Solution 0.125%
 - Sodium Hypochlorite (Dakin's Half Strength) Topical Solution 0.25%
 - Povidone-Iodine (Betadine) Topical Solution 10%

Appendix C: Product of Choice

- **Debriding Agent (Full Thickness Only)**
 - Collagenase (Santyl) Ointment 250 units/g
 - Sodium Hypochlorite (Dakin's Quarter Strength) Topical Solution 0.125%
 - Sodium Hypochlorite (Dakin's Half Strength) Topical Solution 0.25%
- **Hydrogel (All except Intact Skin)**
 - Hydrogel Dressing 6x8in
 - mpm Cooling Dressing 8/12in
- **Emollient (Vanicream) Cream (All except Intact Skin)**
- **Moisture Barrier (Full and Partial Thickness Only)**
 - Skin Protectant Paste 2.5 oz
 - Remedy Clear Aid Ointment 2.5oz
 - Remedy Calazime 0.2%-20% EX Paste
 - Nystatin-Zinc Oxide-Lidocaine Cream (NDX) (CMPD)
- **Medical Grade Honey (All except Intact Skin)**
 - Medihoney Calcium Alginate Dressing
 - Medihoney Hydrocoll Paste Tube
- **Antimicrobial (All except Intact Skin)**
 - Silver (Silvasorb) ER Gel
 - Cadexomer Iodine (Iodosorb) Gel 0.9%
 - Cadexomer Iodine (Iodoflex) Topical Pads 0.9%

Appendix D: Absorbent Dressing of Choice

- **Non-Silver (All except Intact Skin)**
 - ABD pad (4x4in)
 - Allevyn Adhesive Dressing (3x3in, 5x5in)
 - Aquacel Dressing 4x4in
 - Aquacel Rope Dressing 2x45cm
 - Duoderm Xthin Dressing 4x4in
 - Exu Dry Dressing (4x6in, 6x9in, 9x15in, 15x18in, 24x36in)
 - Exu Dry Drain Tube Dressing
 - Exu Dry Leg Dressing
 - Exu Dry Torso Dressing
 - Mepiform Dressing 4x7in
 - Mepilex Border Dressing (4x4in, 6x6in, 6x8in)
 - Mepilex Dressing 4x8in
 - Mepilex Lite Dressing 8x20in
 - Mepilex Sacrum Border Dressing
 - Mepilex Signal Dressing 72x7in
 - Odor Control Carboflex Dressing
 - Wound Odor Dressing 4x4in
- **Silver (All except Intact Skin)**
 - Aquacel Ag Extra Hydrofiber Dressing 4x5in
 - Aquacel Sil Dressing 3/4x18in
 - Mepilex AG Dressing (4x4in, 8x8in)
- **Non-Adherent/Contact Layers (All except Intact Skin)**
 - Vaseline Petro Gauze 3x9in
 - Xeroform Dressing 1x8in
 - Mepitel Dressing (3x4in, 8x12in)
 - Mepitel Dressing One 6.8x10in

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SUGGESTED READINGS

- Ayello EA. Predicting pressure ulcer risk. In: Boltz M, series ed. Try This: Best Practices in Nursing Care to Older Adults. 2003 July. Revised January 2004; Vol 1, No 5. The Hartford Institute for Geriatric Nursing. www.hartfordign.org
- Ayello EA, Braden B. How and why to do pressure ulcer risk assessment. *Adv Skin Wound Care*. 2002 May-Jun;15(3):125-131.
- Baranoski, S., & Ayello, E. A. (2008). Wound care essentials: Practice principles. Lippincott Williams & Wilkins.
- Bergstrom N, Braden BJ, Laguzza A, Holman V. The Braden Scale for Predicting Pressure Sore Risk. *Nurs Res*. 1987;36:205-210.
- Braden Scale for Preventing Pressure Sore Risk. *Prevention Plus*. 2001. Available at: <http://www.bradenscale.com/bradenscale.htm>. Accessed December 16, 2004.
- Cooper, R. (2004). A review of the evidence for the use of topical antimicrobial agents in wound care. *World wide wounds*, 1-11.
- Ennis, W. J., Valdes, W., Gainer, M., & Meneses, P. (2006). Evaluation of clinical effectiveness of MIST ultrasound therapy for the healing of chronic wounds. *Advances In skin & wound care*, 19(8), 437-446.
- Eskes, A. M., Storm-Versloot, M. N., Vermeulen, H., & Ubbink, D. T. (2012). Do stakeholders in wound care prefer evidence-based wound care products? A survey in the Netherlands. *International wound journal*, 9(6), 624-632.
- Lipsky, B. A., & Hoey, C. (2009). Topical antimicrobial therapy for treating chronic wounds. *Clinical infectious diseases*, 49(10), 1541-1549.
- Othman, D. (2012). Negative pressure wound therapy literature review of efficacy, cost effectiveness, and impact on patients' quality of life in chronic wound management and its implementation in the United Kingdom. *Plastic surgery international*, 2012
- Piskozub, Z. T. (1968). The efficiency of wound dressing materials as a barrier to secondary bacterial contamination. *British journal of plastic surgery*, 21(4), 387-401.
- Roberts, R. A. (1994). Pressure Ulcers in Adults: Prediction and Prevention, Clinical Practice Guidelines, Number 3. AHCPR Publication No. 92-0047. *Journal of Neuroscience Nursing*, 26(2), 124-130.
- Seaman, S. (2002). Dressing selection in chronic wound management. *Journal of the American Podiatric Medical Association*, 92(1), 24-33.
- Sood, A., Granick, M. S., & Tomaselli, N. L. (2014). Wound dressings and comparative effectiveness data. *Advances in wound care*, 3(8), 511-529.

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DEVELOPMENT CREDITS

This practice consensus algorithm is based on majority expert opinion of the Wound Ostomy Care workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following medical, radiation and surgical oncologists.

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