Chronic Wound Management Care Guide

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Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient.

SUMMARY

GOALS

- ✓ Obtain wound history, perform assessment, and identify wound type
- ✓ If wound is acute, refer to Triage and Treatment Area (TTA) for evaluation and treatment
- ✓ Refer to Chronic Wound Management Algorithm and Chronic Wound Treatment Table for diagnosis, treatment, prevention and monitoring based on specific wound type
- ✓ Understand Pressure Injury Staging, Braden Scale scoring, and Braden Subscore interventions

ALERTS

- Slow progression of healing
- Signs of local infection or cellulitis
- Signs of systemic infection and/or sepsis
- Increased pain
- Deep abscess
- Non-viable bone
- Critical limb ischemia

DIAGNOSTIC CRITERIA

When wounds or ulcers fail to progress in an orderly and timely manner (approximately 4 weeks) they are diagnosed as chronic or non-healing and require specialized care. Clinical signs of chronicity include: lack of healthy granulation tissue, non-viable tissue (slough and/or necrosis), no reduction in overall size over 2-4 weeks, recurrent tissue breakdown, and presence of wound infection. Wound chronicity is often secondary to the presence of intrinsic and extrinsic factors including comorbidities, compromised nutrition, medications, inappropriate dressing selection, or patient non-compliance.

EVALUATION

Wound History: Onset, prior treatments and diagnostic work-up, past pain, barriers to wound healing

Wound Assessment: All wounds should be assessed and documented using the Wound Care Intake/Management Tool PowerForm (found in the Ad-Hoc section of the Electronic Health Record System [EHRS] patient chart) for the following:

History/Physical Exam

1. Location & Etiology:
   - Location
   - Laterality
   - Type
   - Whether present overlying a bony pressure point
   - Whether present on intake
   - Size
2. Measurements and surrounding tissue characteristics:
   - Length, width, depth
   - Undermining location and depth (if present)
   - Surrounding tissue characteristics (i.e., blistered, bloggy, callus, dry, ecchymosis, edematous, excoriated, friable, hyperthermic, hypothermic, indurated, moist, macerated, painful)
   - Wound edge
   - Surrounding tissue color
   - Wound base color
   - Wound base tissue type
3. Exudate and Dressing Characteristics: exudate amount, exudate type, exudate odor, dressing assessment, cleansing, dressing type, and topical agent

Wound Type: Determine etiology of wound. Etiologies to consider include: pressure injuries, venous ulcers, arterial/mixed ulcers, diabetic foot ulcers (DFU), non-healing surgical wounds

Diagnostic Tests/Procedures: Order based on specific wound type

TREATMENT OPTIONS

- Based on wound type (etiology)
- Refer to Chronic Wound Treatment Table (By Injury/Ulcer/Wound Type), Attachment A
- Mini Chronic Wound Treatment Tables are embedded in each wound type section as well
- Management considerations include:
  - Offloading
  - Compression
  - Assessment of surrounding tissue
  - Cleansing of wound base
  - Exudate control
  - Dead space (undermining, tunneling)
  - Securement
  - Dry intact eschar
  - Suspected infection
  - Debridement
  - CCHCS referral
  - High-priority surgical referral

MONITORING

- **For all inpatients:** Inspect and monitor skin (at least daily) and as clinically indicated: Nursing documentation for any pre-existing wounds can be found in "Wound/Ulcer Assessment" tab of the "Wound Care Intake/Management Tool" PowerForm, and should be completed periodically by Nursing. In the event of an observed, clinical change in the wound, the provider may complete an updated assessment using the same PowerForm tab/page.
- **Monitor outpatients** with limited mobility, incontinence, vascular disease, diabetes mellitus (DM) or other conditions increasing risk for skin ulcer.
- Monitoring guidelines are specific to each wound type.
- Educate patients to monitor their skin for breakdown.
- Change dressings as indicated by type of wound and dressing type.
- Determine if pressure injury preventive measures are necessary.