☐ Rash Protocol
For rashes associated with excessive moisture and / or incontinence

- Gently cleanse area and pat dry
- Apply protective barrier cream with antifungal twice daily and PRN
- Discontinue use of any adult absorbent brief while patient in bed
- Consult wound care clinician if rash is generalized and / or no improvement within 3 days

☐ Skin Tear Protocol
Skin Tear defined as: Traumatic partial thickness injury

☐ Extremities
★ May cut dressings to fit
Cleanse with normal saline and apply the following based on drainage amount:

- Dry to minimal drainage
  - Apply (in this order) Xeroform, Kerlix and 2 inch paper tape
  - Change daily and PRN

- Moderate to heavy drainage
  - Apply (in this order) Xeroform, ABD 1-2 as needed, Kerlix and 2 inch paper tape
  - Change daily and PRN

- Moderate to heavy with bleeding
  - Apply (in this order) Xeroform, Alginate, ABD as needed, Kerlix, and 2 inch paper tape
  - Change daily and PRN

- Non approximated skin tears:
  - Initiate appropriate dressing based on drainage amount
  - Consult wound care clinician

☐ Head and Trunk
★ May cut dressings to fit
Cleanse with normal saline and apply skin barrier wipe:

- Dry to minimal drainage
  - Apply thin hydrocolloid
  - Change weekly and PRN

- Moderate to heavy drainage
  - Apply an adhesive foam dressing or a non-adhesive foam dressing and secure with transparent film
  - Change twice a week and PRN

- Moderate to heavy with bleeding
  - Apply one layer of alginate then apply adhesive foam dressing or a non-adhesive foam dressing and secure with transparent film
  - Change twice a week and PRN

- Non approximated skin tears:
  - Initiate appropriate dressing based on drainage amount
  - Consult wound care clinician

Consult skin and wound assessment team (SWAT) for deterioration at any time or failure to improve within three days.
★ PRN changes can include: moisture, incontinence, soiled, saturated or dislodged dressing

Legend: PRN=as needed; SWAT=skin wound assessment team
<table>
<thead>
<tr>
<th>Pressure Ulcer Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue prevention guidelines and initiate nutrition consult</td>
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<table>
<thead>
<tr>
<th>Stage I Pressure Ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage I is defined as:</strong> Non-blanchable redness with intact skin</td>
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<table>
<thead>
<tr>
<th>Stage I Pressure Ulcer - Heel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Float heel(s) with at least 2 pillows or 4 inch foam cushion <strong>to keep heel(s) off the bed</strong>, if not successful with pillows, then use 4 inch foam cushion</td>
</tr>
<tr>
<td><strong>Do not</strong> use towel rolls under ankle</td>
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<table>
<thead>
<tr>
<th>Stage I Pressure Ulcer - Sacrum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn / tilt patient off sacrum <strong>at least every two hours</strong> even if on special support / turning surface</td>
</tr>
<tr>
<td>Assess patient with each turn and increase turning / tilting frequency as needed</td>
</tr>
<tr>
<td>Evaluate for incontinence at least every two hours:</td>
</tr>
<tr>
<td>- If incontinent or excessive moisture:</td>
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<table>
<thead>
<tr>
<th>Stage I Pressure Ulcer - General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn / tilt patient off affected area <strong>at least every two hours</strong> even if on special support / turning surface</td>
</tr>
<tr>
<td>Assess patient with each turn and increase turning / tilting frequency as needed</td>
</tr>
<tr>
<td>Consider assistive device to reposition to avoid shear injury</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II Pressure Ulcer Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage II is defined as:</strong> Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II Pressure Ulcer - Heel Blister</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paint intact blister daily with Betadine (if no iodine allergy)</td>
</tr>
<tr>
<td>Float heel(s) with at least 2 pillows or 4 inch foam cushion <strong>to keep heel(s) off the bed</strong>, if not successful with pillows, then use 4 inch foam cushion</td>
</tr>
<tr>
<td><strong>Do not</strong> use towel rolls under ankle</td>
</tr>
<tr>
<td><strong>If blister unroofs</strong> follow “Stage II Pressure Ulcer – Open Heel / General” protocol and contact the SWAT representative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage II Pressure Ulcer - Open Heel / General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanse with saline; gently blot dry</td>
</tr>
<tr>
<td>Apply barrier wipe to periwound skin</td>
</tr>
<tr>
<td>Apply alginate; cut 1 to 2 centimeters larger than wound</td>
</tr>
<tr>
<td>Cover with thin hydrocolloid</td>
</tr>
<tr>
<td><strong>For heel wound</strong>: secure / wrap with Kerlix</td>
</tr>
<tr>
<td>Float heel(s) with at least 2 pillows or 4 inch foam cushion <strong>to keep heel(s) off the bed</strong>, if not successful with pillows, then use 4 inch foam cushion</td>
</tr>
<tr>
<td>Change twice weekly and <strong>PRN</strong></td>
</tr>
<tr>
<td>Contact SWAT representative for recommendations as needed</td>
</tr>
</tbody>
</table>

Legend: **PRN** = as needed; **SWAT** = skin wound assessment team
☐ Stage II Pressure Ulcer – Sacral

- Cleanse with saline; gently blot dry
- Apply a protective barrier cream to sacrum twice a day and PRN
- Turn / tilt patient off sacrum at least every two hours even if on special support / turning surface
- Assess patient with each turn and increase turning / tilting frequency as needed (in supine only for meals)
- Consider specialty support surface
- Contact SWAT representative for recommendations as needed

Consult SWAT representative for deterioration at any time or failure to improve in three days.

☐ Stage III and IV Pressure Ulcer

Stage III defined as: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV defined as: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

☐ Stage III and IV Pressure Ulcer – Heel, Sacral and General (Minimal / Moderate / Heavy Drainage)

- Cleanse with normal saline
- Apply barrier wipe to periwound skin
- Apply/fill alginate dressing; cut 1 to 2 centimeters larger than wound
- Apply hydrocolloid dressing
- For heel wound: secure / wrap with Kerlix
- Float heel(s) with at least 2 pillows or 4 inch foam cushion to keep heel(s) off the bed, if not successful with pillows, then use 4 inch foam cushion
- Change dressing every 3 days and PRN
- Turn / tilt patient off sacrum at least every two hours even if on specialty support / turning surface
- Assess patient with each turn and increase turning / tilting frequency as needed (in supine only for meals)
- Consider specialty support surface
- Consult wound care clinician and notify SWAT representative
- If no improvement in one week, notify physician

☐ Unstageable Pressure Ulcer

Defined as: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, green or brown) and / or eschar (tan, brown or black) in the wound bed.

★ Continue pressure ulcer prevention guidelines and initiate nutrition consult

☐ Unstageable Pressure Ulcer – Heel, Sacral and General (Open / Drainage)

- Cleanse with normal saline
- Apply barrier wipe to periwound
- Pack with dry sodium chloride impregnated gauze (i.e. MESALT)
- Cover with non-adherent pad (i.e.Telfa) and transparent film
- May wrap heels with Kerlix and secure with 2 inch paper tape as needed
- Change daily
- Float heel(s) with at least 2 pillows or 4 inch foam cushion to keep heel(s) off the bed, if not successful with pillows, then use 4 inch foam cushion

Legend: PRN=as needed; SWAT=skin wound assessment team
- Do not use towel rolls under ankle
- Turn / tilt patient off sacrum at least every two hours even if on special support / turning surface
- Assess patient with each turn and increase turning / tilting frequency as needed (in supine only for meals)
- Consider specialty support surface
- Consult wound care clinician and notify SWAT representative
- If no improvement in one week, notify physician

☐ Unstageable Pressure Ulcer - Heel, Sacral and General (Closed and Dry)
- Follow prevention guidelines
- Float heel(s) with at least 2 pillows or 4 inch foam cushion to keep heel(s) off the bed, if not successful with pillows, then use 4 inch foam cushion
- Do not use towel rolls under ankle
- Turning schedule (patient in supine position only for meals)
- Keep dry
- Swab daily with Betadine if no iodine allergy
- May wrap heels with Kerlix and secure with 2 inch paper tape as needed
- Consult wound care clinician and notify SWAT representative
- If no improvement in one week, notify physician

▲ PRN changes can include: moisture, incontinence, soiled, saturated or dislodged dressing

☐ Deep Tissue Injury
- Relieve pressure
- Consider specialty support surface
- Notify wound care clinician and SWAT representative
- Notify physician

Additional Orders

Nurse Signature: _____________________________ Date/Time: _____________________________