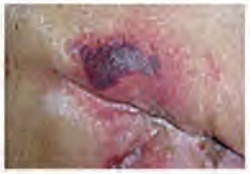
Skin and Wound Care Quick Reference/Guideline

SILVRSTAT



Suspected Deep Tissue Injury (sDTI)

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.

Further description: The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with treatment.

Prevention Guidelines
- Pressure redistribution support surface as appropriate
- Turn and reposition q 2h in bed and q 1h in chair
- Offloading device to keep heels elevated off bed
- Monitor skin at least q 8hrs

Cleanse
- Cleansing Shampoo, Foam, or Body Wash

Apply
- Skin Repair Cream to moisturize skin
- Skin prep for at risk skin
- Zinc prep for compromised skin
- SilvrSTAT for yeast/fungus

Stage I Pressure Ulcer

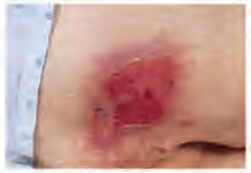
Intact skin with non-blanchable erythema of a localized area usually over a bony prominence. Discoloration of the skin, warmth, edema, hardness or pain may also be present. Darkly pigmented skin may not have visible blanching.

Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.

Intact Skin

Cleanse
- Cleansing shampoo or foam

Apply
- Protective Barrier or Hydrocolloid



Stage II Pressure Ulcer Partial Thickness Skin Loss or Blister

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 or serosanginous filled blister.

Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This category/stage should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

Dry to Scant Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT Hydrogel Cover
- Waterproof bordered gauze

Change
- Daily or as indicated by type and condition of the wound

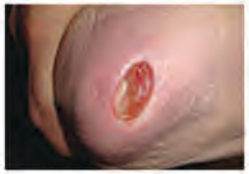
Moderate to Heavy Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT hydrogel to base
- Alginate filler

Cover
- Silicone adhesive foam gentle/Super absorbent dressing

Change
- Daily or as indicated by type and condition of the wound



Stage III Pressure Ulcer or Stage IV Pressure Ulcer or Full Thickness Wound

Stage III: Full Thickness tissue loss (fat visible) Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Some slough may be present. May include undermining and tunneling.

Further description: The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Dry to Scant Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT Hydrogel Cover
- Waterproof bordered gauze

Change
- Daily or as indicated by type and condition of the wound

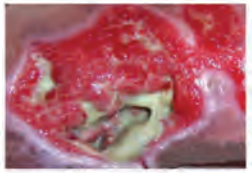
Moderate to Heavy Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT hydrogel to base
- Alginate filler

Cover
- Silicone adhesive foam gentle/Super absorbent dressing

Change
- Daily or as indicated by type and condition of the wound



Stage IV: Full Thickness tissue loss (muscle/bone visible). Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often include undermining and tunneling.

Further description: The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpabl

Dry to Scant Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT Hydrogel Cover
- Waterproof bordered gauze

Change
- Daily or as indicated by type and condition of the wound

Moderate to Heavy Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT hydrogel to base
- Alginate filler

Cover
- Silicone adhesive foam gentle/Super absorbent dressing

Change
- Daily or as indicated by type and

Skin and Wound Care Quick Reference/Guideline

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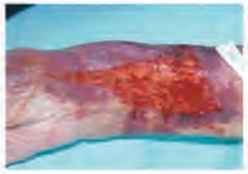
Unstageable Pressure Ulcers Necrotic Wounds

Skin Tear Category I or II



Skin Tear Category III

Colonized or Infected Wounds

Unstageable: Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further description: Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

Category I: Skin tear without tissue loss. Characteristics are based on whether the damage is a linear tear or a skin-flap type tear. Both tears can be fully approximated.

Category II: Skin tear with partial tissue loss. Tears will have a partial thickness epidermal tissue loss. The tears are further classified as scant versus moderate to large tissue loss.

Category III: Skin tear with complete tissue loss where the epidermal flap is absent. These are wounds with complete tissue loss.

Colonized: Bacterial load is high enough that the host is losing control over wound environment may not show critical signs of infection.

Infected: Represents the invasion of bacteria into healthy tissue where they continue to proliferate and elicit a reaction from the host will typically show signs of clinical infection.

Solid Dry Eschar on Heels

Cover
- No Dressing
- Keep Dry

Float heels to relieve pressure

Other Necrotic Wounds with Eschar, Yellow or Black Slough

Cleanse
- Wound Cleanser

Apply
- Skin prep to periwound skin
- Sharp debridement if possible, if not then use an enzymatic debrider for 4 -5 days.
- Following debridement use SilvrSTAT Hydrogel

Cover
- Waterproof bordered gauze

Change
- Daily or as indicated by type

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT Hydrogel to wound

Cover
- Gauze/Rolled Gauze

Change
- Daily or as indicated by type and condition of the wound

Approximate edges when possible with moistened swab

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT Hydrogel to wound bed

Cover
- Silicone adhesive foam gentle/Super absorbent dressing

Change
- Daily or as indicated by type and condition of the wound

Dry to Scant Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT Hydrogel

Cover
- Waterproof bordered gauze

Change
- Daily or as indicated by type and condition of the wound

Moderate to Heavy Exudate

Cleanse
- Normal Saline

Apply
- Skin prep to periwound skin
- SilvrSTAT Hydrogel

Cover
- Calcium Alginate cover dressing

Change
- Daily or as indicated by type and condition of the wound