NURSING PRACTICE GUIDELINE

DATE: December 3, 2009
TITLE: Best wound care practices for pressure ulcers for improved patient outcomes.
PURPOSE: The purpose of this guideline is to provide a standard of care for pressure ulcers to improve patient outcomes.

GUIDELINE:

Nutrition
1. Perform a nutritional assessment with all newly admitted patients and whenever there is a change in patient condition.
2. Encourage dietary intake of protein, carbohydrates, vitamins, and minerals for individuals who have nutritional deficits, if not contraindicated.
3. If dietary intake continues to be inadequate, nutritional support, such as tube feedings, should be used.

Infection
1. Treat infections with appropriate antibiotics in patients that are at risk for pressure ulcers or patients that have a pressure ulcer.
2. Use topical antibiotics when there high number of bacteria and none healing wounds that produce exudate.
3. Remove all necrotic tissue using enzymatic, biological, mechanical, surgical or autolytic debridement.
4. Assess and reassess wound site to evaluate the rate of wound healing and treatment.

Debridement
1. Types of debridement:
   a. Enzymatic debridement- uses topical application of enzymes to remove necrotic tissue.
      1) Use of exogenous proteolytic enzymes to removed dead tissue.
      2) Used with wounds with large amount of debris.
      3) Can be used in patients with bleeding disorders.
      4) Very effective in most patients.
   b. Surgical- uses instruments to remove necrotic tissue. Surgical debridement should be used if there is a large area to be debrided.
      1) Removal of layers of necrotic tissue using a laser, scissors forceps, or curette using sterile technique.
      2) Used best with larger wounds and infected pressure ulcers.
      3) Contraindicated in patient receiving anticoagulants, sepsis, and clotting disorders.
   c. Autolytic- uses the body’s own enzymes to digest necrotic tissue.
      1) Stimulation of natural enzymatic activity by the use of the endogenous enzymes used to digest the dead tissue by use of semi-occlusive or occlusive dressing using transparent films, hydrocolloids, and hydrogels.
      2) Used for large pressure ulcers and deep wounds.
      3) Increase risk of infection with hydrocolloid use.
   d. Mechanical- uses wet-to-dry dressings, wound irrigation and whirlpool techniques. Wet-to-dry dressings may cause more damage by removing viable tissue.
      1) The removal of slough or necrotic tissue by use of wet-to-dry dressing or whirlpool treatment.
      2) Used in wounds with a great amount of necrotic tissue.
3) Least recommended.

**Dressing**

1. Make sure the dressing keeps the ulcer site moist.
   a. Creation of a moist healing environment promotes granulation and reepithelialization of the wound.
   b. Eliminates dead space.
   c. Controls the exudates.
2. Select the appropriate dressing for the wound.
   a. Nondraining Wounds
      i. Transparent film, hydrocolloid, and hydrogel dressings are recommended.
      ii. Hydrocolloid dressings
         1. Decrease the risk of infection.
         2. Should not be used on infected wounds or wounds with undermining, tunneling, or sinus tracts.
         3. Is shown to be superior to saline gauze and paraffin gauze for wound healing.
      iii. Hydrogel dressings
         1. Not recommended for use on heavily draining wounds.
      iv. Transparent dressings
         1. Should not be used on any exudating wounds.
   b. Draining Wounds
      i. Foam, alginate, or collagen dressings are recommended.
   c. Dressings for infected wounds
      i. Occlusive dressings are contraindicated when an anaerobic bacterial infection is present or suspected.
      ii. There has been a positive correlation between gauze dressings and rates of infection.

**SUPPORTING EVIDENCE:**
