GENERAL SURGICAL WOUND CARE

1. **Physician’s Order**
   Surgical wound care shall follow the physician’s orders.

2. **Dressing Changes Using Strict Aseptic Technique**
   If the physician orders dressing changes, the nurse shall use strict aseptic technique. The nurse shall:
   
a. Observe the surgical wound dressing every shift and document status;
   
b. Report any signs of infection or dehiscence to the physician immediately (redness, swelling, in duration, tenderness, separation of the incision, odor, etc.);
   
c. Monitor each shift for changes in skin integrity;
   
d. Ensure patient is turned every two (2) hours while in bed. Document turning, repositioning schedule per flow sheet or in nurses narrative notes;
   
e. Ensure patient changes positions while in chair or wheelchair every hour;
   
f. Use pressure relief device/relieving device to wheelchair, as ordered **do not use donut type devices.**
# APPENDIX A – Treatment Guidelines

<table>
<thead>
<tr>
<th>Type</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| **Skin Tear/Abrasions** | 1. Monitor each shift for changes in skin integrity and document findings.  
2. Consult WOCN to evaluate and make written recommendations.  
3. Notify MD, and follow prescribed treatment, which may include:  
   a. transparent dressing or  
   b. antibiotic ointment; leave wound open to air.  
| **Venous Stasis Ulcer** | 1. Monitor every shift changes in skin integrity and document findings.  
2. Ensure patient is turned every two (2) hours while in bed and document.  
3. Elevate lower extremities while in bed and chair and document.  
4. Low air loss bed as ordered and document.  
| **For ALL Pressure Ulcers** | For all wounds, the RN/LPN shall:  
1. Monitor each shift for changes in skin integrity and document findings.  
2. Ensure patient is turned every two (2) hours while in bed. **Position Patient to remain off the pressure ulcer.** Document position changes.  
3. Provide pressure relief while in chair/wheelchair every two (2) hours.  
4. Use pressure relief mattress/device as ordered (i.e. low air loss mattress Or cushions to wheelchair). **Do not use donut type devices.**  
5. Place normal saline or appropriate dressing on wound as per MD Order.  
6. **If routine dressing changes are ordered,**  
   a. The dressing changes shall be scheduled and written in nurses’ notes.  
   b. After the dressing change is completed, the nurse shall document the time and initial the dressing change and the description of the wound/ulcer in the narrative nurses notes. |
## APPENDIX A – Treatment Guidelines Continued

| Stage 1 Additional Considerations | 1. Use skin care kit.  
| 2. Leave wound open to air.  
| 3. Use heel/elbow pads as indicated.  
| 4. Reposition the patient every 2 hours.  
| 5. Initiate a Hot Spot Turn schedule. |

| Stage 2 Additional Considerations | The following require physician orders prior to implementation by the nurse.  
| a. Lower extremity pressure relief.  
| b. Transparent dressing: Change every other day or more often if dressing becomes dislodged.  
| c. Hydrogel dressing: Change daily or twice/daily.  
| d. Hydrocolloid dressing: Change every 5 days or as ordered.  
| e. All routine dressing changes shall be scheduled according to the WOCN policies/recommendations or physician’s orders. The dressing change schedule shall be written on the nurses notes and the time of completion with the nurse’s initials. (Example: Transparent dressing change: Mon, Wed, Fri, Sun, etc.) |

| Stages 3 & 4 Additional Considerations | 1. Consult Nutritional Services.  
| 2. Daily treatments shall be scheduled and documented on the nurses’ notes and in the narrative notes. The following require physician’s orders prior to implementation by the nurse:  
| a. Lower extremity pressure relief device.  
| b. Clean wound bed with ordered solution prior to dressing application.  
| c. For moderate-heavy drainage, topical treatment options ordered by the MD may include:  
  1) Wound gel to gauze, change everyday as ordered.  
  2) Enzymatic debrider to wound bed for promotion of granulation. Cover with gauze. Change daily as ordered.  
  3) Normal Saline (0.9% sterile Sodium Chloride irrigation) gauze to pack wound. Change twice daily as ordered.  
  4) Lightly pack wounds with sinus tract with normal saline moistened gauze to fill dead space as ordered.  
  5) For heavy drainage, MD may order calcium alginate rope/sheet, Aquacel or foam dressing.  
  6) For moderate to heavy exudates and nonviable tissue necrosis, the MD may order enzymatic debriding agent to agent to necrotic area. |
<table>
<thead>
<tr>
<th>Slough &amp; Eschar Covered Wounds</th>
<th>1. Notify MD &amp; follow orders.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Note wound cannot be staged at this time.</td>
</tr>
</tbody>
</table>