CLINICAL PATHWAYS FOR **WOUND TREATMENT**

Triage pathway for topical wound treatment

Clinical pathway for decubitus/pressure ulcer

Academy

9503324 1213 e

TRIAGE PATHWAY FOR **TOPICAL WOUND TREATMENT**

NECROSIS ⟷ **SLUDGE/BIOFILM**

CLEANING PHASE

GRANULATION PHASE

EPITHELIALIZATION PHASE

Debridement

Infection? Swab

Surgical

Autolytic
Enzymatic
(optional)

Wound cleaning with antiseptics
Depending on spectrum of germs

Wound cleaning with saline solution
0,9 % NaCl or Ringer's solution
(warmed)

Wound description and
objective wound analysis

HBOT - TNP - TWO²
Hydrofibre | foam
Alginates | drawing
Compresses
Activated carbon
Compresses
Superabsorber

Antimicrobial
dressings
Silver,
Polyhexanide

Collagen
Foams adhesive or non adhesive
Gel compresses
Alginate (wound filling)
Hydrocolloid
Film (wound cover)

Dry

Exudate

Gel
(Cave: DFS dry necrosis)
+
Polyurethane dressing

Dressing change interval
on demand 1-3 days

Dressing change interval
on demand 3-7 days

9503324 1213 e

CLINICAL PATHWAY FOR **DECUBITUS/PRESSURE ULCER**

1 Classification (EPUAP)

- Level I: Fixed erythema with intact epidermis. It is not possible to remove reddening with pressure.
- Level II: Blistering, flat ulcer or erosion. Epidermis and dermis are affected.
- Level III: Ulcer and necrosis of all skin levels and the subcutaneous fat tissue
- Level IV: Necrosis affects the subfascial structure as well (bones, tendons and muscles)

Doctor's Admission

2 Prevention

- Estimation of decubitus risk using Braden-scale (decubitus risk under 18 points)
- Set measures (see causal therapy)

WM/admission once per week

3A Diagnostics

- Microcirculation test (grade I)
- Vascular status of the internal iliac artery (decubitus sacral)
- X-ray of the bone if osteomyelitis is suspected
- Blood count (nutrition, systemic infection)
- Proteins, albumin, lymphocytes, transferrin, leucocytes, CRP, fibrinogen
- Smear if critical colonization or infection
- Screening if malnutrition

3B Treatment of underlying diseases Elimination/minimization of risk factors

- Pressure (contact pressure)
- Time (pressure retention period)
- Depression
- Conditions of skin and metabolism
- Urinary tract infection
- Vascular closure
- Malnutrition
- Paralysis

4 Phased wound treatment with specification of infection prophylaxis and treatment

Aim: within 4 weeks – reduction of the wound surface by 50% or 70% of granulation

Causal Therapy

- Pressure reduction
- Skin care
- Mobilization
- Psychic status
- Nutrition (nutrogram)
- Supplementing spur elements and vitamins

Physician/WM

5 Control of therapy strategy (e.g.: lab values, vascular status, biopsy / malignant tumors)

- Sources of irritation
- Allergies
- * Nutrition
- Patient compliance/relatives/staff

Physician/WM

*Stagnating wound healing conditions after 6 weeks

4A Conservative treatment for grade I - II

- Local therapy
- Pressure reduction
- Mobilization

Physician/WM

4B Surgical treatment for grade III - IV

- Necrosectomy
- Flap surgery
- Bursectomy cubital involvement

Physician

4C Specialists

Dermatologist, Internist, Diabetologist, Nutritionist consultant, Psychologist, Plastic surgeon

Condition	TOPICAL TREATMENT THERAPY	
	Infection risk wound (incl. critically colonized) **/ infection** (swab 2-3 cross positive)	**Bact. load** until max. **colonization**
Grade I	Immediate pressure relief	■ Mobilization, exposition of affected site ■ Microbedding ■ Changing pressure mattress ■ Special beds for high risk patients (e.g Low-Flow-bed)
Antimicrobial wound cleansing	Antiseptics: Octenisept PVP-Iodine solution: green exudation (pseudomonas a.o. Gram neg.) Polyhexanide	Saline solution, NaCl 0,9% Ringer's solution Polyhexanide (MRSA)
Necrosis / layers **Biofilm**	Immediate Intervention Debridement with adequate pain therapy →	Debrisoft® scalpel
Persistent coverings	Polytherapy: WF: Prisma (limited time frame!) WC: Suprasorb® P	Polytherapy: WF: Suprasorb® C WC: Suprasorb® H or Vliwazell®
Grade II Severe exudation	Monotherapy: Vliwasorb® Polytherapy with biofilm: ■ WF: Suprasorb® A+Ag WC: Vliwazell® FIX: Mollelast® ■ WF: Kaltostat WC: Vliwazell® Fix: Fixomull® with Pseudomonas:	Monotherapy: Vliwasorb®, Suprasorb® P, Allevyn Gentle Border, Perma foam
Moderate to weak exudation	■ WF: PVP Iodine (limited time!) WC: Vliwasorb® Fix: Mollelast® (according to localization and moderate exudation) ■ WF: Suprasorb® A+Ag WC: Vliwasorb®/ Vliwazell® Fix: Mollelast® (weak exudation) with MRSA, VRE and other problematic microorganisms: ■ WF: Suprasorb® A+Ag WC: Vliwasorb®/ Vliwazell® N Fix: Mollelast®	Polytherapie: WF: Suprasorb® X WC: Suprasorb® F WF: Suprasorb® G FIX: Suprasorb® F
Grade III and IV	**First Line Therapy** - Monotherapy: ■ Suprasorb® CNP, up to 80% granulation tissue and/or less than 50 ml exudation per day ■ Manifested infection VAC silver sponge or VAC-Instill **Second Line Therapy** - Polytherapy: ■ WF: Suprasorb® A+Ag WC: Vliwasorb® FIX: Mollelast® **Third Line Therapy:** - Monotherapy: ■ WF: Vliwasorb® Fix: Mollelast®	**First Line Therapy** - Monotherapy: ■ Suprasorb® CNP, up 80% granulation tissue and/or less than 50 ml exudation per day **Second Line Therapy** - Polytherapy: ■ WF: Suprasorb® A WC: Vliwazell® FIX: Mollelast® **Third Line Therapy** - Monotherapy: ■ Vliwasorb® FIX: Mollelast®
Dry	Polytherapy: WF: Suprasorb® G I WD: Solvaline® N Fix: Mollelast®	Polytherapy: WF: Suprasorb® G WC: Solvaline® N FIX: Mollelast®
Granulation phase	Surgical removal if tissue is infected Polytherapy: WF: Suprasorb® A+Ag WC: Vliwazell® FIX: Mollelast®	Polytherapy: WF: Suprasorb® C WC: Suprasorb® F Monotherapy: Allevyn Gentle Border, Mepilex
Epithelialization phase	Infected tissue can not be removed	Polytherapy: Suprasorb® G FIX: Suprasorb® F
Wound edge protection	Cavilon, Aquacel	not necessary
Skin care	Dline Nutrient with fecal incontinence – Actiflow	Dline Nutrient with fecal incontinence – Actiflow

9503324 1213 e