## E. 2 WOUND CLEANSING ASSESSMENT ALGORITHM

**Wound Assessment**

<table>
<thead>
<tr>
<th><strong>1. Clean Epithelializing Wound</strong></th>
<th><strong>2. Clean Granulating Wound decreasing in size 20-30% in 3-4 weeks</strong></th>
<th><strong>3. Clean Granulating Wound NOT decreasing in size 20-30% in 3-4 weeks</strong></th>
<th><strong>4. Necrotic healable wound where debridement is appropriate</strong></th>
<th><strong>5. Necrotic non-healable wound where debridement is NOT appropriate</strong></th>
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<tbody>
<tr>
<td>DO NOT flush with pressure higher than 7 PSI - pour room or body temperature solution over the wound bed; cleanse the periwound skin. Do not use antimicrobial solutions. Choose a dressing that can be left insitu x 7 days or longer.</td>
<td>DO NOT flush with pressure higher than 7 PSI - pour room or body temperature solution over the wound bed; cleanse the periwound skin. Do not use antimicrobial solutions. Choose a dressing that decreases dressing change frequency.</td>
<td>Flush with 7-15 PSI using at least 150 ccs of solution at room or body temperature, cleanse and protect the periwound skin. Choose a primary antimicrobial dressing, cover with moisture retentive secondary (Debride and cover strategy) *Granulating wounds not decreasing in size may have a localized infection.</td>
<td>Flush with 7-15 PSI using at least 150 ccs of solution at room or body temperature, cleanse and protect the periwound skin. Choose a primary dressing for autolytic or chemical debridement properties; wet necrotic wounds may also need antimicrobial dressings. Choose a secondary dressing with moisture-retentive properties to enhance autolytic debridement. Foul odour indicates anerobes (see # 6)</td>
<td>If there is exudate, cleanse the periwound skin. Pat dry. The intent is to allow the necrotic tissue to dessicate and remain stable; a topical application of poviodine-iodine solution (not detergent scrub) or Chlorhexidine is appropriate. Leave open to air or cover with a loose non-woven gauze that will not be occlusive or adhere to the necrotic tissue.</td>
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*Granulating wounds not decreasing in size may have a localized infection.*
Wound Assessment – Continued

6. Malignant Wounds
Foul odour indicates presence of anerobes- use antimicrobial solution, &/or topical Metronidazole vaginal cream or gel. Friable tumor tissue may not tolerate flushing with 7-15 PSI or hand-held shower. Warm solution to body temperature to decrease discomfort.

7. Wound with debris or contamination/ Superficial & Partial thickness burns
Flush with 7-15 PSI using at least 150 ccs of solution at room or body temperature, cleanse and protect the periwound skin. Choose a primary antimicrobial dressing if desired for prophylaxis, cover with moisture retentive secondary — unless using hydrofiber Ag protocol. May cleanse small burns with lukewarm tap water and mild soap.

8. Tunneling or Undermined Wound
Irrigate using a 5Fr catheter or “soft-cath” with a 30-35 cc. syringe and 150 to 500 cc. solution at room or body temperature. Flush until returns are clear. Gently palpate over undermined or tunneled areas to express any irrigation solution that is retained. Do not force irrigation when resistance is detected. Consult physician if sharp debridement needed.

9. Localized & Spreading Infection
Two week challenge: May use a 10 – 14 day cleansing regime with an antimicrobial solution, flush with 7-15 PSI using at least 150 ccs of solution at room or body temperature, cleanse and protect the periwound skin. Choose a dressing with antimicrobial properties. Spreading infection will need systemic antibiotics in addition to wound toilette. May need to increase dressing frequency until S&S of infection decrease.

10. Maintenance Wounds
Cleansing will be dependent on characteristics of wound bed. If goal is to prevent wound from deteriorating, treat as per # 5.

Re-assess Wound