**Patient Identification Information**

- SISTERS OF CHARITY HOSPITAL • Buffalo, NY
- SISTERS OF CHARITY HOSPITAL • ST JOSEPH Campus • Cheektowaga, NY
- KENMORE MERCY HOSPITAL • Kenmore, NY
- MERCY HOSPITAL • Buffalo, NY
- MERCY HOSPITAL • Orchard Park division • Orchard Park, NY

**Allergies & Sensitivities:**

- No Known Allergies

(Indicates automatic order. MD to draw line through orders to discontinue)

**Wound Care Treatment Orders**

Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber.

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
<th>PRESCRIBER ORDERS</th>
</tr>
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Note:
- Measure all wounds on admission and weekly.
- Wound/Ostomy nurse referral for assessment of Stage III, Stage IV, unstageable and lower extremity wounds
- If patient on bedrest, float heels off bed surface with pillow or heel boot at ALL times

- Wound/ostomy nurse referral

- Incontinence/ dermatitis
  - Cleanse with personal or perineal cleanser. Apply:
  - Protective ointment
  - Dimethicone protectant

- Fungal rash- skin folds
  - Cleanse area and dry thoroughly. Apply 2% miconazole anti-fungal powder to skin folds BID. Separate skin folds with gauze or pillow case; change when damp.

- Fungal rash - perineal/ peri-rectal
  - Cleanse area and dry thoroughly. Apply thin layer of anti-fungal paste to area BID and PRN to keep area protected at all times.

- Skin Tears
  - Select location:
  - Clean area with normal saline solution and pat dry. If possible, pull flap back over skin tear. Apply Vaseline gauze, cover with non-adherent dressing and secure with Kerlix. Change daily.

- Blisters
  - Heel (intact): Apply skin prep BID. Float heels off bed surface with pillows or heel boot
  - Heel (ruptured): For small amount of drainage: apply Vaseline gauze, non-adherent dressing and secure with Kerlix. Change daily. Float heels off bed surface with pillows or heel boot
  - Heel (ruptured): For moderate to large amount of drainage: Apply foam and secure with Kerlix. Change daily. Float heels off bed surface with pillows or heel boot

- Intact, dry black eschar on heels (firm with no S/S infection or drainage).
  - Float heels off bed surface with pillows or heel boot.
  - Apply skin prep BID and allow to dry
  - Paint with povidone-iodine BID and allow to dry (if no iodine allergy)

- Stage I or Deep Tissue Injury (DTI)
  - Location:
  - Assess for improvement/ deterioration/ progression every shift.
  - Institute turning schedule (turn and position every 2 hours), float heels off bed surface with pillow or heel boot.
  - DO NOT COVER OR MASSAGE RED / PURPLE AREAS

- Stage II - partial thickness wound
  - Location:
  - Institute turning schedule (turn and position every 2 hours), float heels off bed surface with pillow or heel boot
  - Cleanse site with normal saline and pat dry. Apply skin prep to surrounding intact skin.
  - For scant/small draining wound: Apply hydrocolloid dressing. Change every 3 days and PRN for lifting/rolling of dressing or strike through of drainage.
  - For moderate/ large draining wound: Apply foam. Change every 3 days and PRN for lifting of dressing or strike through drainage

Prescriber Signature: _______________________________
### Wound Care Treatment Orders

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<tr>
<th>Stage III or Stage IV/ full thickness wound (without necrotic tissue): Location: __________________________</th>
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<tr>
<td>✓ Wound/ostomy nurse referral</td>
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<tr>
<td>✓ Institute turning schedule (turn and position every 2 hours), float heels off bed surface with pillow or heel boot</td>
</tr>
<tr>
<td>✓ Irrigate site with normal saline solution and pat dry. Apply skin prep to surrounding intact skin</td>
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**Scant/small draining wound:**

- Instill hydrogel in wound then fill with fluffed gauze. Cover with dry gauze. Change daily and PRN for strike through of drainage.
- OR
  - Fill wound with hydrogel impregnated conformable gauze. Cover with dry gauze. Change daily and PRN for strike through of drainage.

**Moderate/large draining wound:**

- Fill wound with calcium alginate, cover with foam. Change daily and PRN for strike through of drainage.
- Other treatment: _________________________

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<tr>
<td>✓ Irrigate site with normal saline solution. Apply skin prep to surrounding intact skin. Cover with either a DSD or foam</td>
</tr>
<tr>
<td>✓ Institute turning schedule (turn and position every 2 hours).</td>
</tr>
<tr>
<td>✓ Surgical consult/name ____________________________</td>
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<tr>
<td>✓ Wound Care Center referral</td>
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<tr>
<td>✓ Other treatment: _________________________</td>
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**Lower Extremity Ulcers (i.e. diabetic, venous stasis, or ischemic/ arterial). Location: __________________________ |

- ✓ Wound/ostomy nurse referral |
- ✓ Etiology and treatment of these ulcers are managed by the physician.

**Note:** If poor circulation to extremities and dry eschar is on the heel **DO NOT DEBRIDE.**

**Consults:**

- Wound Care Center consult/referral |
- Vascular/ General surgeon consult: ____________________________ |
- Podiatry consult: ____________________________ |

**Other:**

See progress notes for Recommendations by __________________________ Date __________

**ORDERS EFFECTIVE UPON PRESCRIBER SIGNATURE**

Prescriber signature: __________________________