SISTERS OF CHARITY PROVIDENCE HOSPITALS

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original.
This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Patient Label

Condition	Treatment Plan
❑ Skin tears Location:_______________	• Clean with wound cleanser or normal saline • Apply xeroform or petrolatum gauze, thin layer topically over skin tear and wrap with dry kling • Change daily and PRN (the goal is to prevent drying of dressing to wound bed) **or** cover skin tear with thin foam and change every 3-5 days • Secure either dressing with kerlix, do not apply tape to skin.
❑ Perineal skin care	• Clean with Incontinence wipes w/ Dimethicone • If skin open, apply thin layer of zinc protective barrier in petrolatum base BID and PRN to affected skin. • If signs of yeast, apply thin layer miconazole 2% in petrolatum base ointment BID and PRN to affected area (obtain from pharmacy) • Avoid use of diapers when in bed, check frequently for incontinence
❑ Wound covered with nonviable tissue (eschar/slough) or with evidence of Deep Tissue Injury Location:____________POA: _____ (yes or no) (POA/Present on admission)	• Consult WOC Nurse for wound care recommendations • Keep area dry or apply thin layer of Silvadene cream topically and cover with dry dressing daily • Initiate pressure ulcer prevention/Add to Process Interventions
❑ Stage I pressure ulcer (not on lower extremity) Location:__________ POA:______ (yes or no)	• Can either leave open to air or cover area with a transparent dressing or thin hydrocolloid to help reduce friction • Change every 7days and PRN (rolling up or leakage) • Initiate pressure ulcer prevention/ Add to Process Interventions • Consult WOC Nurse
❑ Stage II pressure ulcers or shallow Stage III (not on lower extremity) Location:___________ Stage:__________ POA:_______ (yes or no)	• Clean area with wound cleanser or normal saline • Cover with hydrocolloid- thin or thick depending on amount of drainage or foam dressing (secure with conformable tape-Hypafix or Medipore) change every 3-7 days and PRN • Initiate pressure ulcer prevention/ Add to Process Interventions • Consult WOC Nurse
❑ Stage III or IV pressure ulcers (full-thickness ulcers with depth) Location:__________ Stage:________ POA :______ (yes or no)	• Clean area with wound cleanser or normal saline • ***If wound dry bed***, apply amorphous hydrogel to wound bed and lightly pack with moist normal saline gauze • Cover with dry gauze and secure with paper tape or conformable tape (Hypafix or Medipore) • Change daily or BID to keep wound bed moist • ***If wound is wet or exudative***, lightly pack with calcium alginate dressing. • Cover with dry gauze and secure with Opsite/Tegaderm or conformable tape (Hypafix or Medipore) • Change daily and PRN, to keep wound moist as well as absorb excess exudate • Initiate pressure ulcer prevention/ Add to Process Interventions • Consult WOC Nurse
❑ Dry eschar to heels Location:____________ POA:______ (yes or no)	• Paint eschar topically with betadine swab daily • Elevate heels off bed with use of assistive device • Initiate pressure ulcer prevention/ Add to Process Interventions • Consult WOC Nurse
❑ Stage II, III or IV present on lower extremity (no signs of infection) Location:__________ Stage:________ POA:________ (yes or no)	• Clean area with wound cleanser or normal saline • If intact blister, leave open to air or cover with adaptic non-adherent and secure with kling- change every 2 days and PRN (monitor site) • If open wound, apply amorphous hydrogel to wound bed, cover with moistened normal saline gauze, secure and change every 12 hours or PRN • Consult WOC nurse • Initiate pressure ulcer prevention/ Add to Process Interventions

I agree with the above assessment and instructions for care:

Physician Signature: ______________________________ Date: ____________ Time: __________

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