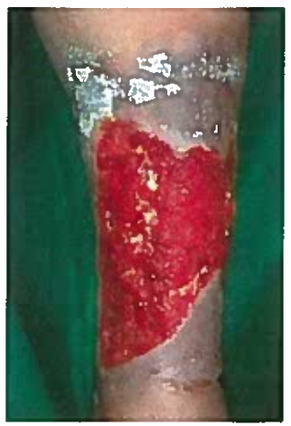
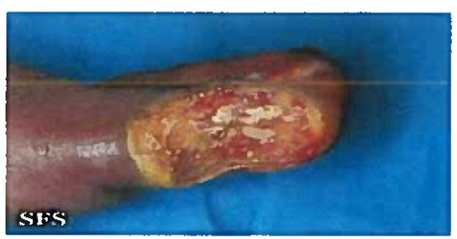
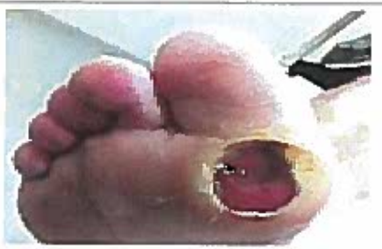
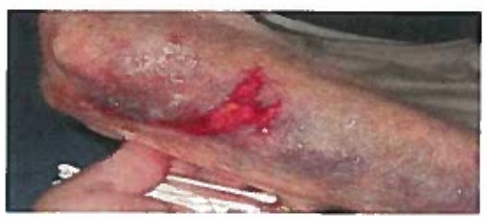
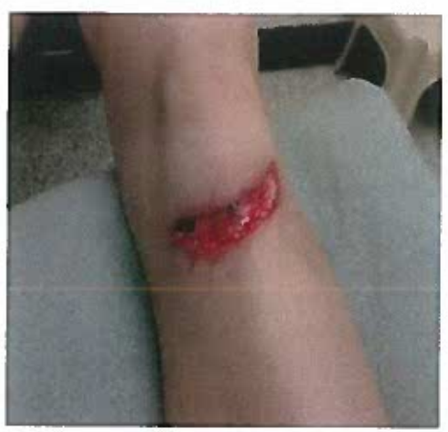
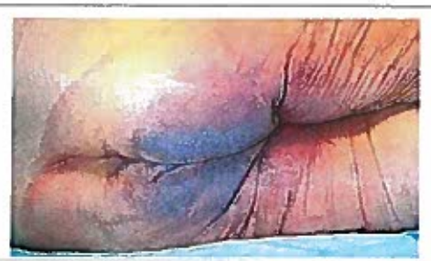
Wound Classification	Exudate Amount	Wound Care per HHVNA Wound Product Formulary	Frequency of Change	Obstacles preventing wound healing
Venous Ulcers				
ABI of 0.9-1.2 = normal blood flow				The patient is not willing or able to eleveate LE, continues to use tobacco, is not able or willing to adhere to low sodium diet.
Elevation of the lower extremeties is strongly recommended to promote venous return to aid wound healing. Wounds are typically located on the lower extremeties in the gaitor region and are irregularly shaped. Peri wound skin often presents w/ hemosiderin staining.				
	Minimal	Restore Hydrogel with cover dressing of choice based on drainage amount	1-2 times/week	
	Moderate	Simpurity Calcium Alginate or Comfort foam with cover dressing of choice	2-3 times/week	
	Heavy	Simpurity Calcium Alginate or Comfort foam with cover dressing of choice; Diapers held in place w/kling wrap or kerlix	3-5 times/week	
Arterial Insufficiency				
NEVER APPLY COMPRESSION TO AN ARTERIAL WOUND	Minimal to None	Restore Hydrogel with cover dressing of choice based on drainage amount	1-2 times/week	Elevation is contraindicated, impedes blood flow, and typically causes pain. Patients continue to regularly use tobacco
Typically located on tips of toes. Small punched out appearance . Peri wound skin may feel cool. Wound bed often pale pink. Necrotic tissue is often present.				
		Betadine paint	3 times/Week/ not skilled/teach	

Wound Classification	Exudate Amount	Wound Care per HHVNA Wound Product Formulary	Frequency of Change	Obstacles preventing wound healing
Diabetic or Neuropathic				
Wounds are located on the plantar portion of the foot or heel. Obtain PT eval for offloading foot wear.	Minimal	Restore Hydrogel with cover dressing of choice.	1-2 times/week	Pt is not willling or able to offload or is not willing or able to wear offloading shoes
	Moderate to Heavy	**Simpurity Alginate or Comfort foam with or without border with cover dressing of choice**	2-4 times/week	
Traumatic Wound				
Skin Tear Approximate edges when able	Minimal	Restore Wound Contact layer remains in place for 7 days/change cover dressing of choice based on drainage amounts.	2 times/week	Patients are not willing to wear long sleeves or pants, and do not use assistive devices as recommended to prevent or reduce falls.
	Moderate to Heavy	Restore Wound Contact layer remains in place for 7 days/change cover dressing of choice based on drainage amounts.	3 times/week	
Other	Minimal	Restore Hydrogel with cover dressing of choice.	2-3 times per week	
	Moderate to Heavy	**Simpurity Calcium Alginate or Comfort foam with or without border with cover dressing of choice**	3-7 times per week	

Wound Classification	Exudate Amount	Wound Care per HHVNA Wound Product Formulary	Frequency of Change	Obstacles preventing wound healing
Pressure Ulcer				
Pressure ulcers are a result of pressure or in combination w/ pressure, shear, or friction. A referral for PT to eval for offloading equipment should be obtained.	None	A&D ointment	2-3 times/day/not skilled/teach	Patient is not able or willing to use or wear offloading equipment (shoes/cushions/mattress).
Stage I				
Intact skin w/ non-blanchable redness of localized area.				
	None	Dukal Transparent Film	1-2 times/week/not skilled/teach	
Stage II				
Partial tissue loss presents as a shallow crater w/ pink healthy wound bed, or as an intact fluid filled blister. *If slough is present the wound must be classified as a **Stage III***	Minimal	Restore Hydrogel with cover dressing of choice or Exuderm LP hydrocolloid	1-2 times/week	Patient is not able or willing to use or wear offloading equipment (shoes/cushions/mattress).
				
Stage III				
Full thickness tissue loss. Subcutaneous tissue is visable, but bone, tendon, or muscle is not visable. Undermining, tunneling, or slough may or may not be be present. Located on pressure points or bony prominences.	Moderate to Heavy	Simpurity Calcium Alginate or Comfort Foam with cover dressing of choice	2-4 times/week	Patient is not able or willing to use or wear offloading equipment (shoes/cushions/mattress). Does not consistently maintain proper inflation settings for RoHo, cushion, or mattress.
				
Stage IV				
Full thickness tissue loss w/ exposed bone, tendon, or muscle. Undermining or tunneling is often present. Slough may or may not be present. Located on pressure points or bony prominences.	Moderate to Heavy	Simpurity Calcium Alginate or Comfort Foam with cover dressing of choice	5-7 times/week	Patient is not able or willing to use or wear offloading equipment (shoes/cushions/mattress). Does not consistently maintain proper inflation settings for RoHo, cushion, or mattress.
				

Wound Classification	Exudate Amount	Wound Care per HHVNA Wound Product Formulary	Frequency of Change	Obstacles preventing wound healing
Unstageable Pressure Ulcer (Stable Eschar) ***Do not debride*** Wound is covered w/ stable eschar. Eschar is acting as a protective dressing. Edges are intact and there is no drainage present. Located on the heel. 	None	Betadine paint	1 time/day Not skilled/Teach	Patient is not able or willing to use or wear offloading equipment (shoes/cushions/mattress) or float heels when indicated.
Unstageable Pressure Ulcer (Unstable Eschar) Slough is present and obscurring ability to view wound. The edges are lifting, the wound has a boggy feel, exudate is present and odorous. Refer to physician for surgical debridement and WOCN ASAP. *Intact blood-filled blisters are classified as unstageable pressure ulcers with suspected deep tissue injury.* 	Minimal to Heavy	Comfort foam with or without border	2-3 times per week	Patient is not able or willing to use or wear offloading equipment (shoes/cushions/mattress) or float heels when indicated.
Deep Tissue Injury				
Presents as intact, darkened skin (blue, purple, maroon) in color. Usually located over a bony prominence due to unrelieved pressure. A referral for PT to eval for offloading equipment should be obtained. 	None	Offloading	Every 2 hours	Patient is not able or willing to offload or is not utilizing offloading equipment correctly.

Wound Classification	Exudate Amount	Wound Care per HHVNA Wound Product Formulary	Frequency of Change	Obstacles preventing wound healing
Surgical				
Is the result of an incision made with a cutting instrument during a sterile procedure.	Minimal to None	Dry clean dressing/gauze/tape or bordered gauze	Daily/prn or per MD order/not skilled/teach	Patient is not able or willing to adhere to activity restrictions. Does not follow recommended diet, continues to use tobacco
Intact				
Edges are approximated with sutures, staples, or adhesive. Patients at risk for dehiscence may be discharged home with non removable dressing that remains in place for (7-10 days).				
				
Dehisced (visible wound bed)	Minimal	Dry clean dressing/gauze/tape or bordered gauze	Daily/prn or per MD order/not skilled/teach	
Edges are open as a result of poor surgical techniques, strenous activity, infection, smoking, comorbidities (diabetes, obesity, renal insufficiency). Refer to surgeon ASAP. Ordering physician may at times order NS/Dakins wet to dry packing w/non-conforming kling wrap daily -bid for the management of acute surgical wound dehiscence. For orders of this nature extending beyond 14 days place referral for HHVNA wound consult.				
	Moderate to Heavy	**Simpurity Alginate or AMD gauze with cover dressing of choice**	3-7 times per week	
Dehisced (non-visible wound bed)	Minimal	Dermaginate rope or AMD gauze packing strip with cover dressing of choice	2-3 times per week	Over packing of the wound; mouth of wound closes before depth fills in
Narrow, deep, tunneled wounds requiring packing with products with specific tensile strenth to facilitate complete removal of wound product. Overpacking impedes tissue granulation and delays wound healing "fluff don't stuff".				
	Moderate to Heavy	Dermaginate rope or AMD gauze packing strip with cover dressing of choice	3- 7 times per week	