MUSKOKA ALGONQUIN HEALTHCARE		**Policy/Procedure Name:**	**Wound Assessment and Management**
Manual:	Nursing	**Number:**	
Section:	General	**Effective Date:**	08 JAN 2021
Pages:	1 of 11	**Revision Date:**	DD MMM YYYY

Purpose

To ensure all wounds at MAHC are assessed in a holistic, standardized fashion and to guide wound management principles.

Scope

The policy pertains to all staff members and physicians at Muskoka Algonquin Healthcare (MAHC).

Policy Statement

All patients at MAHC will have a fulsome wound assessment prior to decision making of wound management. All wounds will be individually assessed and managed as per the goals for healing, determined through assessment.

Definitions

Aseptic Technique: Asepsis means free from pathogenic microorganisms. Aseptic technique can refer to either medical asepsis (clean technique) or surgical asepsis (sterile technique).

Medical Asepsis: Meticulous hand washing, use of a clean field and clean gloves, sterile instruments and prevention of equipment and materials becoming contaminated.

Surgical Asepsis: Meticulous hand washing, use of sterile field, use of sterile gloves for application of sterile dressing, and use of sterile instruments. Sterile equipment and products shall not come in contact with non-sterile materials or surfaces.

Compress: Apply cleansing solution such as saline to sterile gauze with excess fluid wrung out prior to application. Apply moistened sterile gauze to wound bed using sterile forceps. A compress should remain in place for 30- 60 seconds and then be replaced with a second compress for 5-10 minutes.

Depth: The deepest part of a wound.

Exudate: Any fluid, which has come from tissue or its capillaries, including fluid, cells or cellular debris.

Healable: A wound with adequate blood supply that can be healed if the underlying cause is address.

Length: is measured as the longest axis of the wound.

Maceration: softening caused by wetting or soaking.

Peri-wound: the region directly adjacent to the wound edge, which extends until the tissue colour and consistency change.

Maintenance: A wound with healing potential, but also has a patient or health system barrier preventing wound healing from taking place, i.e.: non-adherence to treatment or lack of access to resources.

National Pressure Ulcer Advisory Panel (NPUAP) Staging System: A staging system that describes the depth of tissue involvement in a unilateral dimension of deterioration created by the NPUAP. (Appendix A)

Non-healable: Including palliative wounds, these are wounds, which cannot heal due to irreversible causes or associated illnesses, such as critical ischemia, or malignancy, which is unable to be treated.

Prescriber: A physician, dentist, midwife, or registered nurse in the extended class (nurse practitioner) who has privileges to prescribe within MAHC.

Sinus tract: Also known as tunnelling, a sinus tract is when tissue is destroyed in a specific direction from the surface or edge of the wound. This involves a smaller section of the wound whereas undermining involves a significant section of the wound edge.

Undermining: An area of tissue damage extending under intact skin along the underlying edge of a wound.

Width: Is measured at 90 degrees to the length at the next longest axis.

Wound bed: Is the bottom of the wound and can be described by identifying the type of tissue that is predominant in the wound base according to colour and consistency.

Wound cleansing: Is the process of using non-cytotoxic fluids to reduce the bacterial burden and to remove devitalized tissue, metabolic wastes and topical agents that can delay wound healing, while minimizing wound trauma. 0.9% sodium chloride is recommended for all wound types, as it is compatible with human tissue and is unlikely to cause cellular damage. Certain dressings such as silver based dressings require sterile water solution be utilized instead of saline.

Wound dressings: Cover wounds and serve to provide protection from wound contamination and trauma, provision of compression if bleeding or swelling is anticipated, application of medications, absorption of drainage, or debridement of necrotic tissue.

Wound irrigation: Irrigation uses the mechanical force of a stream of solution to remove debris, bacteria and necrotic tissue from a wound. The pressure needed to irrigate wounds is between 4 and 14 psi (pound per square inch). This pressure can be obtained by using a 100-118 millilitre squeeze bottle, or a 30-35 millilitre syringe with a 19-guage angiocath. The wound should be irrigated with at least 100 to 150 millilitres or a sufficient amount to completely irrigate the entire wound surface. This wound cleansing technique can cause more harm than benefit if the force applied causes more pain or tissue damage. In cases of non-healable or maintenance wounds, extensive irrigation is unnecessary and does not require the same amount of irrigation and force as a healable ulcer.

Procedure

1. A detailed wound assessment shall be completed prior to any wound management decisions. Wound assessment shall occur with each dressing change, at which time the clinical status of the wound and overall patient outcomes shall be evaluated and treatment plan modified if indicated.
2. The wound assessment will be documented in the patient chart utilizing the Incision/Wound Care Power Form.
3. All pressure injuries stage two or greater shall be reported to the MRP and require a physician's order for dressing. If a wound dressing has been initiated by clinical staff, an MRP order must be obtained prior to processing in Cerner.
4. Where a wound assessment proves to be challenging for the MRP and/or MRN, a referral to the Skin and Wound Care Team can be made by following the referral process as indicated in the MAHC Wound Care Binder found in each clinical area.
5. The MRP will be notified immediately if the wound is displaying signs of increased bacterial load and an appropriate dressing selection will be utilized.
6. If infection is suspected in a wound, IPAC shall be notified through a Cerner referral
7. It is the responsibility of every nurse to maintain an up to date knowledge of wound prevention and care. Resources available on LMS and a Wound Care Binder is available in all Clinical areas.
8. Aseptic technique shall be utilized when cleansing and/or dressing a wound.
9. The frequency of dressing change is determined by wound presentation, considering the amount of exudate, type of dressing selected and/or by prescriber order.

Equipment:

a) Clean gloves

b) Disposable wound measurement tool
c) Sterile cotton/foam tip applicator
d) Culture swab, if applicable
e) 0.9 % sodium chloride (single-use) or other wound cleansing solution
f) Sterile dressing tray, if applicable
g) Sterile scissors
h) Sterile gloves, if applicable
i) Appropriate personal protective equipment (PPE) (based on risk assessment and/or additional precautions)
j) Wound dressing product
k) Tape (optional depending on type of dressing selected)
l) Protective waterproof under pad.

Wound Assessment

1. Perform hand hygiene and don PPE where applicable.
2. Introduce yourself to the patient and family using AIDET (Acknowledge, Introduce, Duration, Explanation, Thank).
3. Two identifiers will be used to identify patients.
4. Ensure patient privacy and comfort.
5. Explain the procedure to the patient.
6. Assess patient's level of pain on a scale of 0 to 10.
7. Administer pain medication if required as ordered 30 minutes prior to dressing change.
8. Review patient's wound history, medical history, goals, quality of life issues, nutritional intake and pain.
9. Assess the patient for allergies such as to adhesives or to antiseptics.
10. Review orders for wound care dressing procedure.
11. Assess if the patients family is willing or able to participate in the dressing change.
12. The nurse or care provider will employ aseptic technique when cleansing and dressing wounds.
13. Prepare supplies on bedside table to best facilitate performing procedure.
14. Position patient, expose wound site, adjust lighting, and place a water-proof barrier under the affected region.
15. Perform hand hygiene.
16. Open sterile dressing tray, if applicable.
17. Establish sterile surface.
18. Apply non-sterile gloves and other appropriate PPE, based on risk assessment.
19. Remove existing dressing, examining for quality and quantity of drainage and odour.
20. The following assessment shall be undertaken when a wound is located on an extremity:

a) Assessing for a regional pulse.
b) If a wound is located on a foot, a dorsalis pedis pulse shall be assessed by palpation, and if felt, arterial flow should support wound healing as this indicates 80mmHg is present.
c) If a wound is located on a hand or arm, a radial pulse may be utilized to determine if appropriate arterial supply is present as if present it would indicate 70mmHg is present to support wound healing.
d) If no pulse is palpable, the MRP shall be notified, as further testing should be considered.
e) If compression is being considered further testing shall be undertaken prior to application, such as an Ankle Brachial Pressure Index, Arterial Doppler, or Computed Tomography Angiography. If this testing has not been completed the MRP shall be notified.
Note: An Ankle Brachial Pressure Index may not be accurate if the patient is diabetic.

21. Assessment of the wound includes the following information:
    a) Location and etiology of the wound.
    b) If a pressure injury, stage of the wound according to NPUAP staging system (refer to Appendix A).
    c) Size of wound (length, width, and depth):
        i. Wound size measurements shall provide information related to wound healing and allow progress to be monitored
        ii. Wound measurement can be completed using a disposable ruler
    d) Presence of sinus tracts, undermining, or tunneling
        i. A sterile cotton tip applicator can be utilized for measuring under the wound edge, or measuring wound tunneling
        ii. Using your thumb and index finger grip the applicator at the point where it is equal to the surface of the skin and measure the distance from your finger to the end of the applicator
        iii. Undermining and tunneling shall be documented using the anatomical clock.
    e) Appearance of the wound bed including presence of or probing to any exposed bone
        i. If during probing bone is felt, the MRP shall be notified of the possible risk of osteomyelitis
    f) Exudate (type and amount)
    g) Odour
    h) Condition of the peri-wound skin and wound edges
    i) Level of Bacterial Load
22. Referrals should be made to interdisciplinary health care providers as appropriate (e.g. Occupational Therapist, Physiotherapist, Dietitian, and Pharmacist). A discussion with the MRP shall take place regarding those health care providers whose consultation requires an order.
23. If cultures of the wound are ordered:

a) Irrigate the wound with 0.9% sodium chloride until loose debris has washed away.
b) Utilizing a moist swab (may utilize 0.9% sodium chloride to moisten swab), swab a 1 cm area of the cleanest and deepest part of the wound and/or area of granulation tissue.
c) Use enough pressure to release tissue exudate for a period of five seconds.
d) Do no swab exudate or slough

24. Based on wound assessment document on patients health record if the wound should be healable, if it should be considered maintenance, or non-healable due to assessment findings.

Wound Management

1. Perform hand hygiene and don appropriate PPE equipment based on risk assessment.
2. Irrigate or compress the wound with a non-cytotoxic cleansing solution such as 0.9% sodium chloride. Do not irrigate into unexplored tunnels or cavities that the fluid cannot be retrieved from. If irrigating, remove any excess fluid from the wound base.
3. Using forceps and sterile gauze, dry the peri-wound area.
4. Protect the peri-wound area using skin barrier as appropriate.
5. Prior to determining dressing choice, refer to the MAHC Pressure Injury Management Guidelines (Appendix B) and MAHC Wound Care Management Product Use (Appendix C).
6. Determine appropriate dressing based on:
   a) A comprehensive assessment
   b) Consultation with the inter-professional team
   c) Wound ability to heal
   d) Debridement needs
   e) Inflammation/infection
   f) f. Moisture balance
   g) Wound edge
   h) Protection from contamination of outside organisms
   i) Reducing wound and peri-wound trauma
   j) Patient preference
   k) Maintaining wound integrity (i.e. not leaving fibres/debris in the wound)
   l) Nursing time, ease of use, and cost
   m) For wound products and their attributes refer to the MAHC Product Formulary found in the MAHC Wound Care Binder in clinical areas.
7. Obtain prescriber order as required for pressure injury staging 2 or greater.
8. Apply selected dressing according to manufacturer's instructions.
9. Clean up dressing supplies, disposing of PPE, sharps and biohazardous waste appropriately.
10. Perform hand hygiene.
11. Reposition patient and assess tolerance of procedure.

12. Develop a patient specific interprofessional wound care plan for continuity of care. This includes appropriate referrals and informing the MRP of the wound.
13. Document the initiated or ordered dressing on the patient health record. Mark dressing with date changed. Any information that is not captured on the wound care documentation record shall be documented as a comment or Clinical note in Cerner.

Cross Reference

Pressure Injury Prevention Policy and Procedure

Notes

Standardized Statement:

References / Relevant Legislation

National Pressure Ulcer Advisory Panel. (2016). National Pressure Ulcer Advisory Panel (NPUAP) announces a change in terminology from pressure ulcer to pressure injury and updates the stages of pressure injury. Retrieved from: https://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announcesa-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-thestages-of-pressure-injury/

Perry, A.G., Potter, P.A., Ostendorf, W.R. (2014). Clinical Nursing Skills and Techniques (8th ed). 920-975. Missouri, USA: Mosby Inc.

Registered Nurses' Association of Ontario. (2007). Assessment and Management of Stage I to IV Pressure Ulcers (Revised). Toronto, Canada: Registered Nurses' Association of Ontario.

Registered Nurses' Association of Ontario. (2016). Assessment and Management of Pressure Injuries for the Interprofessional Team (Third Edition). Toronto, Canada: Registered Nurses' Association of Ontario: https://rnao.ca/bpg/guidelines/pressure-injuries
Wounds Canada. Best Practice Recommendations for Prevention and Management of Wounds. https://www.woundscanada.ca/docman/public/health-care-professional/bpr-workshop/165-wc-bpr-prevention-and-management-of-wounds/file

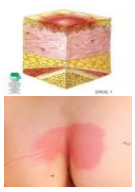
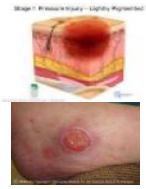
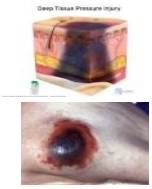
Appendices

Appendix A – MAHC's National Pressure Ulcer Advisory Panel Staging Guide
Appendix B – MAHC Pressure Injury Management Guidelines
Appendix C – MAHC Wound Care Product Management Use

Appendix A - MAHC's National Pressure Ulcer Advisory Panel Staging Guide

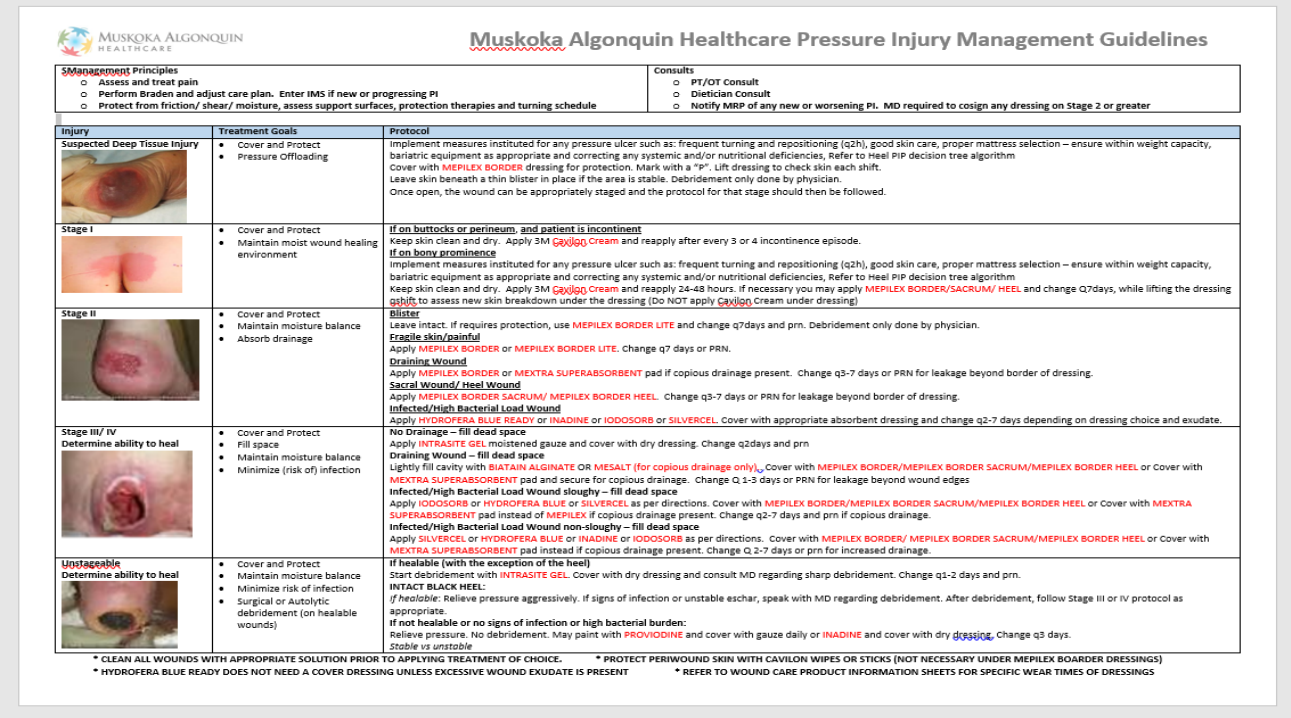
MUSKOKA ALGONQUIN HEALTHCARE

Pressure Ulcer Stages

Stage I Pressure Injury	Stage II Pressure Injury	Stage III Pressure Injury	Stage IV Pressure Injury	Deep Tissue Pressure Injury	Unstageable Pressure Injury
Non-blanchable erythema of intact skin Intact skin with localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Colour changes do not incluce purple or mar0on discoloration; thes may indicate deep tissue pressure injury.	**Partial-thickness skin loss with exposed dermis** Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visable and deeper tissues are not viable. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture-assosicated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive-related skin injury (MARSI), or taumatic wounds (skin tears, burns, abrasions).	**Full-thickness skin loss** Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury	**Full-thickness loss of skin and tissue** Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If sough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.	**Persistent non-blanchable deep red, maroon or purple discoloration** Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin colour changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dematologic conditions.	**Obscured full-thickness skin and tissue loss** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heels(s) should not be softened or removed.
					

Developed by MAHC Wound Care Team referencing from www.npuap.org April 2020

Appendix B – MAHC Pressure Injury Management Guidelines



MUSKOKA ALGONQUIN HEALTHCARE

Muskoka Algonquin Healthcare Pressure Injury Management Guidelines

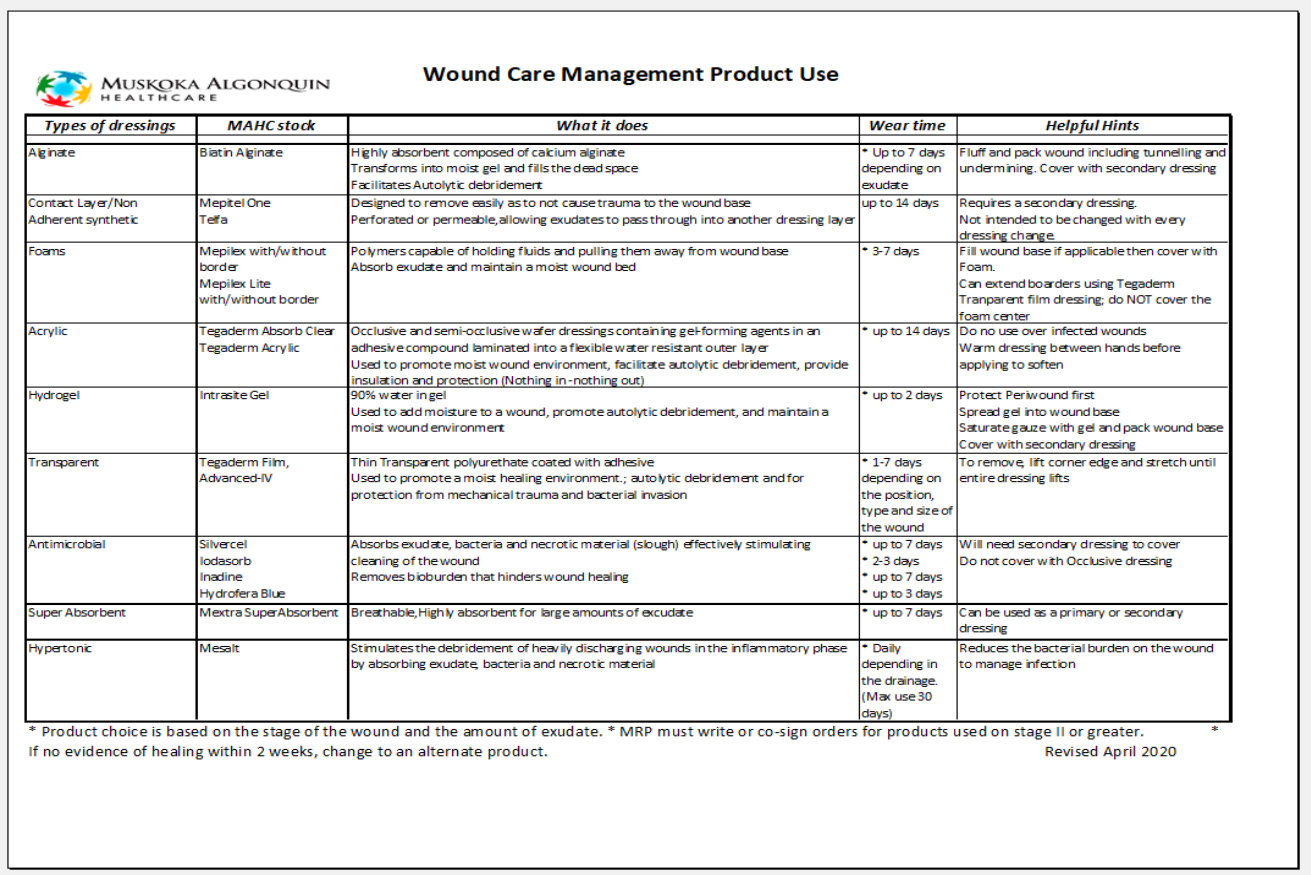
Management Principles
- Assess and treat pain
- Perform Braden and adjust care plan. Enter IMS if new or progressing PI
- Protect from friction/ shear/ moisture, assess support surfaces, protection therapies and turning schedule

Consults
- PT/OT Consult
- Dietician Consult
- Notify MRP of any new or worsening PI. MD required to cosign any dressing on Stage 2 or greater

Injury	Treatment Goals	Protocol
Suspected Deep Tissue Injury	• Cover and Protect • Pressure Offloading	Implement measures instituted for any pressure ulcer such as: frequent turning and repositioning (q2h), good skin care, proper mattress selection – ensure within weight capacity, bariatric equipment as appropriate and correcting any systemic and/or nutritional deficiencies, Refer to Heel PIP decision tree algorithm Cover with MEPILEX BORDER dressing for protection. Mark with a "P". Lift dressing to check skin each shift. Leave skin beneath a thin blister in place if the area is stable. Debridement only done by physician. Once open, the wound can be appropriately staged and the protocol for that stage should then be followed.
Stage I	• Cover and Protect • Maintain moist wound healing environment	**If on buttocks or perineum, and patient is incontinent** Keep skin clean and dry. Apply 3M Cavilon Cream and reapply after every 3 or 4 incontinence episode. **If on bony prominence** Implement measures instituted for any pressure ulcer such as: frequent turning and repositioning (q2h), good skin care, proper mattress selection – ensure within weight capacity, bariatric equipment as appropriate and correcting any systemic and/or nutritional deficiencies, Refer to Heel PIP decision tree algorithm Keep skin clean and dry. Apply 3M Cavilon Cream and reapply 24-48 hours. If necessary you may apply MEPILEX BORDER/SACRUM/ HEEL and change Q7days, while lifting the dressing qshift to assess new skin breakdown under the dressing (Do NOT apply Cavilon Cream under dressing)
Stage II	• Cover and Protect • Maintain moisture balance • Absorb drainage	**Blister** Leave intact. If requires protection, use MEPILEX BORDER LITE and change q7days and prn. Debridement only done by physician. **Fragile skin/painful** Apply MEPILEX BORDER or MEPILEX BORDER LITE. Change q7 days or PRN. **Draining Wound** Apply MEPILEX BORDER or MEXTRA SUPERABSORBENT pad if copious drainage present. Change q3-7 days or PRN for leakage beyond border of dressing. **Sacral Wound/ Heel Wound** Apply MEPILEX BORDER SACRUM/ MEPILEX BORDER HEEL. Change q3-7 days or PRN for leakage beyond border of dressing. **Infected/High Bacterial Load Wound** Apply HYDROFERA BLUE READY or INADINE or IODOSORB or SILVERCEL. Cover with appropriate absorbent dressing and change q2-7 days depending on dressing choice and exudate.
Stage III/ IV **Determine ability to heal**	• Cover and Protect • Fill space • Maintain moisture balance • Minimize (risk of) infection	**No Drainage – fill dead space** Apply INTRASITE GEL moistened gauze and cover with dry dressing. Change q2days and prn **Draining Wound – fill dead space** Lightly fill cavity with BIATAIN ALGINATE OR MESALT (for copious drainage only). Cover with MEPILEX BORDER/MEPILEX BORDER SACRUM/MEPILEX BORDER HEEL or Cover with MEXTRA SUPERABSORBENT pad and secure for copious drainage. Change Q 1-3 days or PRN for leakage beyond wound edges **Infected/High Bacterial Load Wound sloughy – fill dead space** Apply IODOSORB or HYDROFERA BLUE or SILVERCEL as per directions. Cover with MEPILEX BORDER/MEPILEX BORDER SACRUM/MEPILEX BORDER HEEL or Cover with MEXTRA SUPERABSORBENT pad instead of MEPILEX if copious drainage present. Change q2-7 days and prn if copious drainage. **Infected/High Bacterial Load Wound non-sloughy – fill dead space** Apply SILVERCEL or HYDROFERA BLUE or INADINE or IODOSORB as per directions. Cover with MEPILEX BORDER/ MEPILEX BORDER SACRUM/MEPILEX BORDER HEEL or Cover with MEXTRA SUPERABSORBENT pad instead if copious drainage present. Change Q 2-7 days or prn for increased drainage.
Unstageable **Determine ability to heal**	• Cover and Protect • Maintain moisture balance • Minimize risk of infection • Surgical or Autolytic debridement (on healable wounds)	**If healable (with the exception of the heel)** Start debridement with INTRASITE GEL. Cover with dry dressing and consult MD regarding sharp debridement. Change q1-2 days and prn. **INTACT BLACK HEEL:** *If healable:* Relieve pressure aggressively. If signs of infection or unstable eschar, speak with MD regarding debridement. After debridement, follow Stage III or IV protocol as appropriate. **If not healable or no signs of infection or high bacterial burden:** Relieve pressure. No debridement. May paint with PROVIODINE and cover with gauze daily or INADINE and cover with dry dressing. Change q3 days. *Stable vs unstable*

* CLEAN ALL WOUNDS WITH APPROPRIATE SOLUTION PRIOR TO APPLYING TREATMENT OF CHOICE. * PROTECT PERIWOUND SKIN WITH CAVILON WIPES OR STICKS (NOT NECESSARY UNDER MEPILEX BOARDER DRESSINGS)
* HYDROFERA BLUE READY DOES NOT NEED A COVER DRESSING UNLESS EXCESSIVE WOUND EXUDATE IS PRESENT * REFER TO WOUND CARE PRODUCT INFORMATION SHEETS FOR SPECIFIC WEAR TIMES OF DRESSINGS

Appendix C – MAHC Wound Care Management Product Use



MUSKOKA ALGONQUIN HEALTHCARE

Wound Care Management Product Use

Types of dressings	*MAHC stock*	*What it does*	*Wear time*	*Helpful Hints*
Alginate	Biatin Alginate	Highly absorbent composed of calcium alginate Transforms into moist gel and fills the dead space Facilitates Autolytic debridement	* Up to 7 days depending on exudate	Fluff and pack wound including tunnelling and undermining. Cover with secondary dressing
Contact Layer/Non Adherent synthetic	Mepitel One Telfa	Designed to remove easily as to not cause trauma to the wound base Perforated or permeable, allowing exudates to pass through into another dressing layer	up to 14 days	Requires a secondary dressing. Not intended to be changed with every dressing change
Foams	Mepilex with/without border Mepilex Lite with/without border	Polymers capable of holding fluids and pulling them away from wound base Absorb exudate and maintain a moist wound bed	* 3-7 days	Fill wound base if applicable then cover with Foam. Can extend boarders using Tegaderm Tranparent film dressing; do NOT cover the foam center
Acrylic	Tegaderm Absorb Clear Tegaderm Acrylic	Occlusive and semi-occlusive wafer dressings containing gel-forming agents in an adhesive compound laminated into a flexible water resistant outer layer Used to promote moist wound environment, facilitate autolytic debridement, provide insulation and protection (Nothing in-nothing out)	* up to 14 days	Do no use over infected wounds Warm dressing between hands before applying to soften
Hydrogel	Intrasite Gel	90% water in gel Used to add moisture to a wound, promote autolytic debridement, and maintain a moist wound environment	* up to 2 days	Protect Periwound first Spread gel into wound base Saturate gauze with gel and pack wound base Cover with secondary dressing
Transparent	Tegaderm Film, Advanced-IV	Thin Transparent polyurethate coated with adhesive Used to promote a moist healing environment.; autolytic debridement and for protection from mechanical trauma and bacterial invasion	* 1-7 days depending on the position, type and size of the wound	To remove, lift corner edge and stretch until entire dressing lifts
Antimicrobial	Silvercel Iodasorb Inadine Hydrofera Blue	Absorbs exudate, bacteria and necrotic material (slough) effectively stimulating cleaning of the wound Removes bioburden that hinders wound healing	* up to 7 days * 2-3 days * up to 7 days * up to 3 days	Will need secondary dressing to cover Do not cover with Occlusive dressing
Super Absorbent	Mextra SuperAbsorbent	Breathable, Highly absorbent for large amounts of excudate	* up to 7 days	Can be used as a primary or secondary dressing
Hypertonic	Mesalt	Stimulates the debridement of heavily discharging wounds in the inflammatory phase by absorbing exudate, bacteria and necrotic material	* Daily depending in the drainage. (Max use 30 days)	Reduces the bacterial burden on the wound to manage infection

* Product choice is based on the stage of the wound and the amount of exudate. * MRP must write or co-sign orders for products used on stage II or greater. *
If no evidence of healing within 2 weeks, change to an alternate product. Revised April 2020