WOUND CARE QUICK REFERENCE GUIDE

Mend WOUND SOLUTIONS

For Primary Care Providers & Specialists mendmywound.com · 719-922-1002 Fax: 719-888-1841

Manage in-office when appropriate. Refer when you should. We're here when you need us.

1. Initial Wound Assessment — Key Questions to Answer at Every Visit

DOMAIN	ASSESS	DOCUMENT
Wound basics	Location · Size (L×W×D in cm) · Shape · Stage/classification	Measure at every visit. Note % change from prior.
Tissue type	Granulation · Slough · Eschar · Epithelial · Exposed structure	Estimate % of each tissue type in wound bed.
Wound edges	Attached vs. rolled/epibole · Undermining · Tunneling	Probe gently with cotton tip. Document depth/direction.
Exudate	Amount (none/scant/mod/heavy) · Color · Consistency · Odor	Odor + purulence = infection until ruled out.
Periwound skin	Erythema · Maceration · Induration · Hyperpigmentation · Edema	Erythema >2cm from wound edge suggests cellulitis.
Pain	0–10 scale · At rest vs. with care · Character (burning, aching)	Increasing pain in a previously comfortable wound = infection flag.
Systemic factors	HbA1c · Albumin/prealbumin · ABI · Medications (steroids, anticoagulants)	Optimize glycemic control. Target HbA1c <7.5 for wound healing.

2. Manage In-Office vs. Refer to Specialist — Decision Framework

✓ YOU CAN MANAGE IN-OFFICE	→ REFER TO MEND WOUND SOLUTIONS
✓ Superficial abrasions or lacerations healing normally	→ Any wound present >4 weeks without measurable improvement
✓ Stage I–II pressure injuries in low-risk patients	→ Wound enlarging or deepening despite appropriate treatment
✓ Minor post-surgical wounds with healthy granulation	→ Exposed tendon, capsule, fascia, or bone
✓ Acute wounds < 2 weeks with clear etiology	→ Diabetic foot ulcer of any depth or duration
✓ Simple venous ulcers responding to compression	→ Stage III–IV pressure injuries or unstageable wounds
✓ Minor diabetic foot skin breakdown, intact sensation	→ Signs of infection not resolving with oral antibiotics
✓ Wounds showing >50% size reduction in 4 weeks	→ Wounds requiring debridement beyond your comfort level
	→ Venous ulcers failing compression after 4–6 weeks
	→ Arterial or mixed etiology wounds (ABI <0.8)

	→ Wounds needing NPWT, skin substitutes, or amniotic membrane
	→ Any wound in an immunocompromised or malnourished patient

3. In-Office Management Guide by Wound Type

Diabetic Foot Ulcer (DFU)	**Manage when:** Wagner Grade 0–1 (superficial, no infection, palpable pulse)
In-Office Steps	**Refer to Mend if:**
1. Offload immediately — total contact cast, CAM boot, or felt padding 2. Debride non-viable tissue (sharp, enzymatic, or autolytic) 3. Moist wound healing: hydrocolloid or foam dressing 4. Check ABI if vascular status unknown 5. Optimize glycemic control — target HbA1c <7.5 6. Assess and address nutritional status	■ **Grade 2+, any signs of infection, no improvement in 2 weeks, or ABI <0.8**

Venous Leg Ulcer (VLU)	**Manage when:** Confirmed venous etiology, ABI >0.8, no acute infection
In-Office Steps	**Refer to Mend if:**
1. Initiate compression therapy: 4-layer bandage or 20–30mmHg stockings 2. Moist wound environment: foam, alginate, or hydrofiber dressing 3. Elevate affected limb >30° for 2–4 hours/day 4. Address edema: diuretics if cardiac etiology 5. Patient education on compression compliance 6. Reassess at 4 weeks — measure wound area	■ **ABI <0.8, wound not reducing by ≥40% in 4 weeks, recurrent ulceration, or suspected mixed etiology**

Pressure Injury (Stage II)	**Manage when:** Partial thickness skin loss, intact or open blister, no slough/eschar
In-Office Steps	**Refer to Mend if:**
1. Eliminate pressure: reposition q2h, pressure-redistributing mattress 2. Clean with normal saline or wound cleanser 3. Moisture-retentive dressing: hydrocolloid or thin foam 4. Protect periwound skin with barrier cream 5. Optimize nutrition: protein 1.2–1.5g/kg/day, Vitamin C, Zinc 6. Reassess every 3–5 days	■ **Stage III–IV, unstageable, suspected deep tissue injury, or no improvement in 2 weeks**

4. Wound Infection Recognition & Response

CONTAMINATION / COLONIZATION Manage Locally	LOCAL INFECTION Treat + Monitor Closely	SPREADING / SYSTEMIC INFECTION Refer Urgently or ER
• Bacteria present but no host response	• Increased pain, erythema >2cm	• Erythema spreading rapidly
• No classic infection signs	• Warmth, edema, purulent exudate	• Systemic signs: fever, chills, confusion
• No change in treatment required	• Odor or delayed healing	• Lymphangitis / lymphadenopathy
• Routine cleansing sufficient	• → Topical antimicrobials (silver/iodine)	• Crepitus (gas in tissue)
	• → Consider oral antibiotics	• Hemodynamic instability
	• → Culture before antibiotics if possible	• → IV antibiotics likely needed
	• → Reassess in 48–72 hours	• → Call Mend: 719-922-1002

5. Quick Dressing Selection Guide

WOUND CONDITION	RECOMMENDED DRESSING	CHANGE FREQUENCY	AVOID
Dry / minimal exudate	Hydrocolloid, hydrogel sheet	Every 3–5 days	Dry gauze (desiccates wound)
Moderate exudate	Foam dressing, hydrofiber	Every 2–3 days	Occlusive if infected
Heavy exudate	Alginate, superabsorbent	Daily or every other day	Hydrocolloid (leaks)
Infected / biofilm	Silver foam, iodine-based, DACC	Daily until controlled	Occlusive dressings
Slough / necrotic tissue	Enzymatic (collagenase) or hydrogel	Every 1–2 days	Dry dressings
Granulating wound	Silicone foam, low-adherent contact layer	Every 3–5 days	Adherent dressings
Fragile / periwound skin	Soft silicone, bordered foam	Per manufacturer	Adhesive products

6. Nutritional Optimization for Wound Healing

NUTRIENT	TARGET / DOSE	ROLE IN HEALING	FLAG IF
Protein	1.2–1.5 g/kg/day (up to 2.0g in severe wounds)	Collagen synthesis, immune function, tissue repair	Albumin <3.5 or prealbumin <15
Vitamin C	500–1,000 mg/day	Collagen cross-linking, antioxidant, immune support	Smokers, poor diet, chronic illness
Zinc	25–50 mg/day elemental zinc (short-term supplementation)	Epithelialization, immune function, protein synthesis	Deficiency common in elderly; don't over-s
Vitamin D	Optimize to 40–60 ng/mL	Immune modulation, antimicrobial peptide production	Most elderly patients are deficient
Arginine	Found in wound-specific formulas (e.g. Juven, Arginaid)	Nitric oxide production, tissue perfusion, collagen	Pressure injuries Stage III–IV, surgical wou
Calories	30–35 kcal/kg/day	Prevents catabolism; protein used for energy if insufficient	BMI <18.5 or >10% unintentional weight lo