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Clinical Practice Guideline for Wound Care Management in Primary Healthcare Settings Across the British Virgin Islands to Minimize Clinical Practice Variations

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Walden University

College of Nursing

This is to certify that the doctoral study by

Trorisia Shanika John

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University

2025

Executive Summary: Clinical Practice Guideline
Clinical Practice Guideline for Wound Care Management in Primary Healthcare Settings
Across the British Virgin Islands to Minimize Clinical Practice Variations

by

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MS, Walden University, 2022

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Executive Summary Submitted in Partial Fulfillment
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Summary

This quality improvement (QI) initiative in a British Virgin Islands (BVI) primary healthcare setting involved the problem of inconsistent wound care management among registered nurses, which was a concern that was identified in a 2023 audit. The BVI Health Service Authority (HSA)'s diverse nursing staff, which is recruited across the Caribbean, contributed to varied wound care approaches, negatively impacting healthcare delivery and quality. These inconsistencies led to unequal resource access, increased infection and complication risks, and potential financial and legal liabilities. Furthermore, it could negatively affect staff and patient perceptions, potentially decreasing patient satisfaction, highlighting the urgent need for standardized and evidence-based clinical practice guidelines (CPGs).

This project involved implementing a CPG for BVI primary care nurses to improve patient outcomes and care quality. This involved addressing how standardized CPG implementation could reduce variations in wound care management. Four AGREE II-experienced experts assessed the guideline during refinement, yielding satisfactory findings with high domain scores (70%-77%). The evaluation highlighted the guideline's robust quality and appropriateness, noting its well-defined scope, inclusive stakeholder involvement, rigorous evidence-linked development, clear presentation, consideration of implementation factors, and freedom from bias. This research and data-driven approach involved creating a CPG that standardized practices and improved efficiency, ultimately leading to more consistent and safer wound care. Implementing this guideline was expected to promote equity in terms of resource allocation and service delivery while encouraging positive social change, diversity, and inclusion within the healthcare system.

Background

CPGs are evidence-based recommendations that are crucial for guiding and enhancing patient care. They are used to minimize unnecessary inconsistencies and improve quality by evaluating treatment options (De Leo et al., 2023; Pereira et al., 2022). Practice gaps leading to inefficiencies and increased risks are exacerbated by clinical practice variation differences in treatments for similar conditions, creating disparities in terms of access, use, and quality (Bashkin et al., 2022; Sutherland & Levesque, 2020).

A 2023 audit by the BVIHSA revealed significant inconsistencies in wound care management by registered nurses, many of whom come from diverse Caribbean backgrounds. This variation negatively impacted healthcare delivery, leading to unequal resource access, increased infection risks, financial and legal concerns, and potentially poor staff and patient perceptions.

Absence of standardized wound care guidelines amplifies clinical practice variations, increasing the potential for complications (Bishop, 2021). Implementing consistent and evidence-based wound assessment, dressing selection, and followup protocols is essential for positive patient outcomes and aligning with national standards (Bishop, 2021). Inconsistent wound treatment, characterized by varying knowledge and skills, insufficient evidence-based practice (EBP), and overuse of ineffective interventions, results in delayed healing, increased pain and costs, prolonged hospital stays, and greater illness (Pereira et al., 2022; Raveglia et al., 2021). Furthermore, lack of CPGs hinders QI efforts by providing no shared benchmarks for evaluating and ensuring adherence to optimal care practices (Raveglia et al., 2021; Wang et al., 2023). Therefore, clear and evidence-based clinical recommendations are critically needed to address these issues.

A comprehensive search was used to identify and select seven peer-reviewed journal articles that were published between 2020 and 2024. These sources included three Level III, two Level IV, and two Level V publications. Evaluating overall quality of evidence indicated three articles included strong and compelling support, while four included consistent findings. Insights from these seven articles were relevant to addressing the specific EBP question guiding this project.

This project involved developing and implementing an evidence-based wound care guideline for registered nurses within the BVI primary care system to improve patient outcomes and quality of care. Consequently, the most suitable approach to address this gap in practice was a QI initiative. This involved investigating the following question: How will implementing a standardized CPG within the primary healthcare setting reduce variations in wound care management?

CPG Development

Four experts evaluated the CPG: the Director of Public Health Nursing, Director of Quality, Infection Control Manager, and Public Health Nurse Manager. The Director of Public Health Nursing has over 30 years of nursing leadership experience and a Master of Public Health degree. Her expertise includes developing programs, policies, and CPGs. The Director of Quality has over 20 years of healthcare experience and a Master of Science in Nursing. She was involved in reviewing and approving BVIHSA policies and CPGs. The Infection Control Manager has over 25 years of service and a Master of Public Health degree. She led the development of the primary healthcare setting's wound care policy and reviewed and approved infection control policies and CPGs. The Public Health Nurse Manager is a certified wound care specialist with a Master of Public Health degree.

She contributed to developing the wound care policy and reviewed and approved BVIHSA wound care policies and CPGs. These experts were selected for their combined expertise in terms of public health, QI, infection control, and nursing leadership, ensuring a comprehensive CPG evaluation.

The CPG's methodological quality was systematically assessed using the AGREE II tool (Next Steps Consortium, 2017). It is used to evaluate guidelines across six domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence. Furthermore, each item is scored on a seven-point Likert scale, where one indicates strong disagreement and seven indicates strong agreement with assessment criteria. Experts used a standardized scoring process for each item within these domains to assess the CPG's quality.

AGREE II Review Process

Methodological quality of the CPG was assessed using the AGREE II tool. Each expert independently assigned scores and provided written feedback for the six domains. Following these individual assessments, experts convened to discuss their evaluations, address any differences in opinion, and reach a consensus regarding the CPG's overall quality. Moreover, key stakeholders and end-users reviewed the proposed CPG for clinical relevance. Feedback from registered nurses highlighted implementation feasibility, clarity of recommendations, and resource availability, resulting in detailed instructions and a resource checklist. Wound care specialists emphasized comprehensiveness, alignment with best practices, and potential outcome improvements, leading to added guidance on advanced dressings and algorithms. Modifications were made to the CPG based on feedback and consensus during the AGREE II review.

Implications

The 2023 audit revealed inconsistencies in terms of wound care management among registered nurses, leading to unequal resource access and increased risks for the organization. Implementing this CPG is expected to improve wound healing rates by standardizing protocols, reducing infection rates and decreasing antibiotic use, enhancing consistency in wound care across all clinics, increasing staff competence through standardized training, improving patient satisfaction by ensuring evidence-based care, and optimizing wound care resources by promoting appropriate product selection. By addressing practice gaps and promoting evidence-based care, the CPG will improve patient outcomes and quality of care.

The project and resulting CPG had limitations: limited patient input may affect needs and adherence. Evidence gaps led to reliance on expert consensus, leading to subjectivity. Resource constraints may hinder uniform implementation and scope, limiting applicability to other settings. These limitations were considered during the AGREE II evaluation and implementation planning.

The project is vital beyond the setting for several reasons: it serves as a model for similar settings, contributes to EBP, and addresses global challenges. The CPG can guide other small island nations and resource-limited settings with similar healthcare systems. The AGREE II tool is applicable in various contexts. This project adds to knowledge on effective strategies for standardizing wound care practices and improving patient outcomes in primary care. Emphasizing evidence-based recommendations and systematic guideline development can inform other healthcare organizations who are looking to enhance their wound care services. The challenge of inconsistent wound care and need for

standardization is not unique to the BVI. Many healthcare systems face similar issues, and this project shows how CPGs can address this global challenge. Sharing results and lessons can improve wound care quality and patient outcomes worldwide.

Results

The AGREE II assessment revealed consistently high scores, ranging from 70% to 77% across all six domains. In accordance with criteria for high-quality guidelines as 60% or higher in most or all domains, these results affirmed the guideline's robust quality and suitability for the organization's specific context and objectives. Feedback from four experts revealed the AGREE II tool offered a structured methodology for evaluating CPGs. They noted it provided a nuanced understanding of guideline strengths and limitations. This comprehensive appraisal enhanced confidence in reliability of guidelines meeting criteria. Standardized formatting of specific items and the scoring system allowed for consistent evaluations by different reviewers, improving objectivity and comparability (see Table 1).

Table 1*AGREE II Domain Scores*

Domain	Domain Score
Scope and Purpose	72%
Stakeholder Involvement	75%
Rigor of Development	74%
Clarity of Presentation	75%
Rigor of Development	77%
Clarity of Presentation	75%
Applicability	74%
Editorial Independence	72%

Conclusions

This wound care CPG, which was found to be satisfactory, promises significant improvements for the BVIHSA by addressing existing inconsistencies in wound care delivery. Implementation of this CPG is anticipated to foster quicker wound healing, reduce incidence of infections (and consequently antibiotic usage), promote more significant equity in terms of care provision, enhance nursing staff competence, elevate patient satisfaction levels, and optimize resource use.

To further strengthen the CPG's effectiveness and facilitate its seamless integration into practice, several key recommendations were proposed: establishment of routine assessment protocols, development of robust strategies to promote guideline adherence, adoption of a standardized CPG format, use of comprehensive checklists during its ongoing refinement, and enhancement of communication channels among all relevant stakeholders. Prioritizing these recommendations based on their feasibility and potential impact could prove advantageous.

The CPG has substantial implications for nursing practices and broader social dynamics within the BVIHSA. It will enhance nurses' skills, knowledge base, and overall professional confidence and proficiency. Its core emphasis on delivering high-quality healthcare was intended to drive positive social change and foster improved coordination within the primary care setting. CPG development must explicitly acknowledge and incorporate cultural and linguistic variations to address diverse patient populations. Furthermore, to ensure equity, it should actively mitigate existing disparities involving access to care in order for all patients receive necessary and appropriate treatments. Integral to the CPG's successful development and implementation is meaningful involvement of a broad spectrum of stakeholders, fostering a truly inclusive and collaborative process.

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Appendix

Wound Care Clinical Practice Guideline

Activity	Recommendation	Level of Evidence/Quality ratings	Comments	Source of Evidence
<p>1. Definitions</p> <p>A wound: a break or injury of a membrane (skin, dermis, epidermis) or underlying tissues that may result from underlying medical or physiological disorders or damages (physical, mechanical, or thermal).</p> <p>Physical damage: refers to any minor or severe harm, injuries, or damages to the skin or bony prominence caused by accidents, violence, or other harmful actions.</p> <p>Mechanical damage: refers to injuries such as abrasions, grazes, or lacerations, to the body from a blow, knife wound, crush, cut, bullet wound, bite, or penetrating wounds.</p> <p>Thermal damage: refers to injuries that occur from transfers of heat sources (radiation, flames, friction, frostbite, chemicals, and electricity) to the body causing an increase in local tissue temperature (burns).</p>	<p>Strongly Recommended:</p> <p>Establishes a foundation for mutual understanding, communication, and transparency.</p>	<p>Level I: Good Quality</p>	<p>To avoid misunderstandings and achieve clarity without being repetitive.</p>	<p>(Zens et al., 2020)</p>
<p>2. Wound Types and Classification</p> <p>Acute Wound: These are sudden superficial to deep wound injuries (damage to blood vessels, nerves, and muscles) that have no underlying etiology to disrupt a normal inflammatory response that allows the wound to proceed through the healing process at the predictable, expected, timely manner and rate (within four to six weeks).</p> <p>Chronic Wound: These wounds exceed the predictable, expected, timely manner and rate of the wound healing process and require secondary</p>	<p>Strongly Recommended:</p> <p>An important predictor of risks that provides clinical, economic, and educational analysis, as well as outcomes on quality reports.</p>	<p>Level III: Good Quality</p>	<p>Assist in tracking and identifying differences for improved decision-making.</p>	<p>(Ding et al., 2022)</p>

<p>intentions to promote healing. A chronic wound is characterized by complications, underlying pathology, and a persistent state of inflammation that may prolong, interrupt, and delay healing. For example, leg ulcers, fungating lesions, diabetic foot ulcers, and pressure injuries are classified as chronic wounds.</p> <p>Non-Healing Wound: These are wounds classified as non-achievable healing by a multi-disciplinary team. The primary goal of care for non-healing wounds is to maximize patient comfort and control symptoms such as exudate, odor, and pain.</p> <p>3. Procedure Initial Assessment in Clinical Facility</p> <p>Hand Hygiene must be performed using soap and water or with 70% alcohol-based hand sanitizer.</p> <p>A comprehensive initial assessment using the Braden skin risk assessment tool and the wound (s) status (history, age, location, shape, dimensions, extent of tissue injury, etiology factors, exudates, measurement (length, width, depth), undermining and tunneling, drainage, presence of infection, wound base characteristics, healing, and peri-wound skin and edges condition) is performed. All clinical findings must be documented only by a Registered Nurse/ Registered Nurse Midwife/ certified wound care specialist/ wound care nurse of the primary healthcare department.</p> <p>On the initial assessment, each identified wound (s) must be numbered, photographed, and swabbed for MRSA screening (If a wound (s) appears/is suspected to be infected, separated swabs are performed for microscopy, culture, and sensitivity screening). All clinical findings must be documented, and each collected sample must be labeled correctly specifying the location of the sample on the approved microbiology specimen request form and sent to the laboratory within 2 hours of collection.</p>	<p>Strongly Recommended:</p> <p>Identify stages of healing and provide early intervention to address concerns or influencing factors.</p>	<p>Level II: Good Quality</p>	<p>Offer opportunities to collect information about wound health status, facilitating early diagnosis and treatment plans.</p>	<p>(Kolimi et al., 2022)</p>
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<p>The multidisciplinary team (physician, registered nurse, nutritionist) in conjunction with the patient, family, and care team, shall develop an appropriate individualized care plan based on the patient’s evaluation, unique medical condition, needs, and assessment findings. The attending physician must approve the finalized plan of care.</p> <p>The attending clinician will provide instruction and education (wound care & self-management) to the patient /caregiver.</p> <p>Based on the patient findings referrals to the Interdisciplinary team members (Physiotherapy, Social Worker, Dietician, and Diabetes and Wound Specialist) must be made as appropriate to address risk factors, maximize function, and promote healing.</p> <p>Initial Assessment in at Home</p> <p>Hand Hygiene must be performed using soap and water or with 70% alcohol-based hand sanitizer.</p> <p>A comprehensive initial assessment using the Braden skin risk assessment tool and the wound (s) status (history, age, location, shape, dimensions, extent of tissue injury, etiology factors, exudates, measurement (length, width, depth), undermining and tunneling, drainage, presence of infection, wound base characteristics, healing, and peri-wound skin and edges condition) is performed is by a Registered Nurse/ Registered Nurse Midwife/ certified wound care specialist/ wound care nurse and the District/ attending physician of the primary healthcare department. All clinical findings must be documented clearly and legibly until information can be transferred to the organization system. All information collected during home care must be destroyed to ensure patient privacy.</p> <p>On the initial assessment, each identified wound (s) must be numbered,</p>	<p>Strongly Recommended:</p> <p>Identify stages of healing and provide early intervention to address concerns or influencing factors.</p>	<p>Level II: Good Quality</p>	<p>Offer opportunities to collect information about wound health status, facilitating early diagnosis and treatment plans.</p>	<p>(Kolimi et al., 2022)</p>
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<p>photographed, and swabbed for MRSA screening (If a wound (s) appears/is suspected to be infected, separated swabs are performed for microscopy, culture, and sensitivity screening). All clinical findings must be documented, and each collected sample must be labeled correctly specifying the location of the sample on the approved microbiology specimen request form and sent to the laboratory within 2 hours of collection.</p> <p>The multidisciplinary team (physician, registered nurse, nutritionist) in conjunction with the patient, family, and care team, shall develop an appropriate individualized care plan based on the patient’s evaluation, unique medical condition, needs, and assessment findings. The attending physician must approve the finalized plan of care.</p> <p>The attending clinician will provide instruction and education (wound care & self-management) to the patient /caregiver.</p> <p>Based on the patient findings referrals to the Interdisciplinary team members (Physiotherapy, Social Worker, Dietician, and Diabetes and Wound Specialist) must be made as appropriate to address risk factors, and appropriate adaptive equipment and pressure redistribution support surfaces will be suggested to the patient/ family member or sourced to maximize function and promote healing.</p> <p>4. Wound assessment</p> <p>Wound assessment shall be guided by utilizing the TIME framework.</p> <ul style="list-style-type: none"> •T – Tissue Nature of the wound bed: granulation tissue, condition (healthy/unhealthy) epithelialization tissue, sloughy or necrotic tissue, or eschar. The component should be recorded as a percentage of the wound bed. 	<p>Strongly Recommended:</p> <p>Provides a description of the type and amount of tissue present for comparison.</p>	<p>Level II: Good Quality</p>	<p>Identifies barriers to healing to implement plan of care that promotes wound healing.</p>	<p>(Sussman, 2023)</p>
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<p>•I – The presence of Infection/ Inflammation: Odor (offensive, some/none), colonization/Infection (suspected/ confirmed), Pain (specifying site, frequency (continuously/intermittent) and severity).</p> <p>•M – The presence of Moisture Exudates: colour, type, approximate amount/extent of strike from primary and/or secondary dressings or bandages.</p> <p>•E – The characteristic of the Edge Wound dimensions: Measurement (length, width, depth), skin condition (fragile, dry, macerated eczema, inflamed), sinus formation, and undermining of surrounding skin, wound margins characteristics (edema, color, erythema (measure extent), and maceration.</p> <p>5. Wound Swab</p> <p>The following wound types should be swabbed:</p> <ul style="list-style-type: none"> •Acute wounds that show signs of wound infection (spreading redness, pus, increased pain/swelling, and fever). •Chronic wounds that show signs of spreading or systemic infection. •Critically colonized/locally or clinically infected and deteriorating wounds that do/ have not responded to appropriate treatment (topical antimicrobial). <p>NB: Swab results should confirm which antibiotic regime is the most appropriate.</p> <ul style="list-style-type: none"> •For wounds suspected to be critically colonized a two-week anti-microbial dressing challenge without microbiological swabbing is appropriate. 	<p>Strongly Recommended:</p> <p>To identify the causative organism and ensure appropriate treatment is essential initiated.</p>	<p>Level I: Good Quality</p>	<p>Supply valuable data to enhance diagnostic and therapeutic decision-making.</p>	<p>(Ahmed et al., 2024)</p>
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<p>6. Antibiotic Regime</p> <p>Systemic antibiotics are only used in the presence of systemic and spreading infection. Antibiotics should be prescribed in line with local antibiotic prescribing policies.</p> <p>NB: Antibiotic changes should be in response to the result of a swab.</p> <p>Topical antimicrobials</p> <p>When selecting an antimicrobial, the following should be taken into consideration by the wound care team: An environment that provides/promotes an optimal healing environment.</p> <p>Select effective and efficient antimicrobials to manage symptoms (exudates, pain) and minimize resistant bacterial strains (restrict the use of systemic antimicrobials).</p> <p>Complete comprehensive assessment for topical sensitization and/or allergic reactions.</p> <ul style="list-style-type: none"> •Iodine-based products •Silver products •Polyhexamethylene biguanide (PHMB) •Mesalt •Honey (ensure patients are not allergic to bee stings). 	<p>Strongly Recommended:</p> <p>To prevent the development of bacterial resistance and effectively treat critically colonized or locally infected wounds with topical antiseptics.</p>	<p>Level III: Good Quality</p>	<p>Effective use can aid in preventing and treating infections in wound care management.</p>	<p>(Yousefian et al., 2023)</p>
<p>7. Wound Cleansing</p> <p>Wound cleansing is integral for wound bed preparation and aims to remove bacteria, remnants, and surface contaminants (gross contamination) with minimal pain and trauma and prevent biofilm activity.</p> <ul style="list-style-type: none"> •A sterile solution of 0.9% sodium chloride or sterile water is appropriate for irrigating healthy acute wounds. •Showering is appropriate in the case of chronic wounds. •Irrigation fluids must be close to body temperature with care to avoid trauma to tissues or splash back. 	<p>Strongly Recommended:</p> <p>Provides a systematic approach for removing exudate and debris to prepare the wound bed, creating optimal conditions for healing.</p>	<p>Level II: Good Quality</p>	<p>To reduce the likelihood of using techniques that lead to impairment and hinder optimal wound healing.</p>	<p>(Sussman, 2023)</p>

<p>•Non- filamented should be used for wiping. Only surrounding skin should be dried, the actual wound bed should not be dried as wiping may leave fibers that could be a focal point for infection or damage newly formed tissues.</p> <p>•Antiseptics/disinfectants and dyes are not recommended for general use as they are cytotoxic to fibroblasts.</p> <p>8. Selection of Wound Dressing Product</p> <p>The ideal dressing products ensures that wounds:</p> <ul style="list-style-type: none"> • Are not macerated but remain moist with exudate. • Absolved from clinical infection and excessive slough. • Devoid toxic chemicals, particles, or fibers. • Maintain optimum temperature and pH value for healing. • Undisturbed from frequent changes. <p>When choosing the appropriate wound management products, the Registered Nurse/ Registered Nurse Midwife/ certified wound care specialist/ wound care nurse of the primary healthcare department should only adhere to the wound care guidelines recommended by the attending physician.</p> <p>The selected wound-dressing products should be appropriate for promoting a moist environment for the stages of the wound-healing matrix and meeting the needs of the wound-dressing interface.</p> <p>The products should be comfortable for the patient (s)/client (s) and consider factors such as odor control, patient acceptability, and the type and location of the wound.</p> <p>When selecting a product, the patient (s)/ client (s) culture and beliefs must be considered. The patient (s)/ client (s) must be provided with clear information and accept the selected wound-care dressing products.</p>	<p>Strongly Recommended:</p> <p>Offer insight into the healing process alongside knowledge of the different properties of available dressings.</p>	<p>Level II: Good Quality</p>	<p>Selecting the right wound dressing is essential for promoting healing, lowering treatment expenses, and enhancing the patient's overall health.</p>	<p>(Nguyen et al., 2023)</p>
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<p>Wound-dressing product use must be consistent with the instructions and guidelines of the manufacturer.</p> <p>If there are issues such as leakage or strikethrough of the dressing barrier using the selected wound-care products, the dressing should be changed. If leakage or strikethrough occurs frequently in the dressing products, the attending physician must be notified, and the wound care team must re-evaluate the products.</p> <p>Each dressing site must be re-evaluated after one week to determine the effectiveness of the selected dressing products. If the adverse reaction to the dressing product is identified, the attending physician must be notified, and the wound care team must re-evaluate the products.</p> <p>The number of dressings, dressing product effectiveness, and the assessments/evaluations of each wound must be documented correctly in the organization’s electronic system.</p> <p>9. Types of Wound Dressings</p> <ul style="list-style-type: none"> •Gauze •Foam – constructed from polyurethane foam, primarily used for minor burns, pressure injuries, diabetic ulcers, and skin grafts. •The transparent film - is primarily used for lacerations, Intravenous (IV) sites, second-degree burns, surgical incision sites, and abrasions. •Hydrocolloid - primarily used on wounds with drainage burns (light to moderate), pressure injuries, venous ulcers, and necrotic wounds. •Hydrogel- is primarily used on wounds with dead tissues (necrotic) and dry wound areas. 	<p>Strongly Recommended:</p> <p>Promotes proper wound healing and minimizes the risk of infection.</p>	<p>Level I: Good Quality</p>	<p>Prevents complications caused by contamination or disruption.</p>	<p>(Tran et al., 2023)</p>
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<p>10. Staff Education and Competency Testing</p> <p>The Clinical Nurse Educator will provide education/ training on skin and wound care topics such as assessment, identifying and determining wound etiology, documentation, product selection and use, and wound care technique to the newly hired and current Registered Nurses/ Nurse Midwives of the Primary Health Care Department.</p> <p>Wound care in-service training on negative pressure wound therapy and multilayer compression wraps will be provided to the Registered Nurse, Registered Nurse Midwife, certified wound care specialist, and wound care nurse of the primary healthcare department.</p> <p>For newly hired Registered Nurses of the Primary Health Care Department, orientation, training competency assessment, and staff development for basic wound care in-service training will be provided.</p> <p>Field and visit competency assessments for basic wound care, suture, staple removal, and negative pressure wound therapy will be conducted for registered nurses, registered nurse midwives, certified wound care specialists, and wound care nurses of the primary healthcare department.</p> <p>Additional education on varying topics based on patient outcome reporting, feedback, and as needed will be provided community-wide for registered nurses, registered nurse midwives, certified wound care specialists, and wound care nurses of the primary healthcare department.</p>	<p>Strongly Recommended:</p> <p>Provide continuing education, critical mass evidenced-based practice mentor, and time and monetary support to clinicians enhance the success of the implemented CPG.</p>	<p>Level I: Good Quality</p>	<p>Provide support and professional development for clinicians to enhance their knowledge, attitude, skill, confidence levels, and organizational readiness related to wound care evidence-based practice.</p>	<p>(Connor et al., 2023)</p>
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