Perley Health's Field Guide

Building an Effective Skin and Wound Care Program

Perley Health
Centre of Excellence in Frailty-Informed Care™

Nothing short of excellent.

Contact Information

This guide is available free for download on the Perley Health website at PerleyHealth.ca/building-an-effective-skin-and-wound-care-program.

For more information on this document, please consult the Centre of Excellence website at PerleyHealth.ca/centreofexcellence.

Or contact us at:

Perley Health
Centre of Excellence in Frailty-Informed Care™

Perley Health Centre of Excellence in Frailty-Informed Care™

1750 Russell Road, Ottawa ON K1G 5Z6

centreofexcellence@perleyhealth.ca

Office: 613-526-7170 ext. 2425

The Skin and Wound Care Field Guide Project Team:

Daniela Acosta, Centre of Excellence, Perley Health
Samantha Boulerice, Nursing, Perley Health
Melissa Norman, Quality and Interprofessional Care, Perley Health
Jennifer Parker, Quality and Interprofessional Care, Perley Health

Special Acknowledgement

1. Credit for the clinical and quality improvement work described in this field guide goes to **Samantha Boulerice, RN, BScN, NSWOC, WOCC(C) and the interprofessional team at the point of care.**
2. Perley Health's skin and wound care program is supported, in part, through the generosity of **donors** who all share a commitment to transforming care for Seniors and Veterans.
3. Thank you to **Nicole Lafleche, Perley Health Resident,** for sharing her personal story on wound care and healing with us, and the greater Perley Health community.

How to Cite

Perley Health. (2025). *Building and Effective Skin and Wound Care Program*. PerleyHealth.ca/building-an-effective-skin-and-wound-care-program

Copyright

Continuous Improvement

Please note that we view this as a living document. Our culture of self-improvement ensures that, together, we are always striving for a higher standard of excellence. We welcome feedback from all users—residents, caregivers, implementation leads, staff, and administrators. Please share your experiences, comments, or questions by emailing: centreofexcellence@perleyhealth.ca.

Updated: September 30, 2025

Declaration Statement

The work outlined in this document details the development of the Skin and Wound Care program at Perley Health and done in partnership with the Registered Nurses Association of Ontario (RNAO) though Best Practice Spotlight Organization Canada.

Assumptions and Scope

This field guide assumes the reader is familiar with change management principles and does not explicitly explore implementation science methodologies. We strongly encourage your team to choose a quality improvement framework when adopting any of the change ideas shared in this document.

Our team utilizes the Model for Improvement as described in Health Quality Ontario's Quality Improvement Guide. We also use the Knowledge-to-Action Framework and Social Movement Action Framework as outlined in the RNAO's Leading Change Tookit.

See below for more details:

- Health Quality Ontario. (2012). *Quality Improvement Guide*: https://www.hqontario.ca/portals/0/documents/qi/qi-quality-improve-guide-2012-en.pdf
- Registered Nurses Association of Ontario (2024). *Leading Change* Toolkit: https://rnao.ca/bpg/leading-change-toolkit

"Every licensee of a long-term care home... [shall implement] ... a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions"

– O. Reg. 246/22, FLTCA, 2021

Building an Effective Skin and Wound Care Program

Letter from the CEO

It is with great pleasure that Perley Health announces the release of our first quality improvement field guide. Your engagement with this document is a testament to our shared dedication to providing the highest quality of care to residents in long-term care.

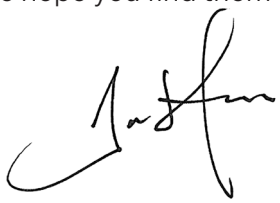
Establishing an effective, evidence-based skin and wound care program can be transformative for residents living with frailty, particularly those with vulnerable skin or existing wounds. As the body's largest and most visible organ, healthy skin plays a crucial role in enhancing quality of life. By prioritizing skin health, residents can experience reduced pain, greater autonomy, and more opportunities to lead meaningful, engaged lives.

There are many ways to build an effective skin and wound care program. We aim to share insights from our improvement journey to help others on the same path build their programs more efficiently. Our story highlights continuous improvement and practical solutions that were tailored to address common challenges in long-term care, particularly at the point of care.

This field guide contains ideas, insights, and notes from our quality improvement experience. Implementation of this program resulted in sustained improvements in key clinical outcomes, including a decrease of more than 50 percent in both worsening pressure injuries and skin and wound infections. This document includes:

1. 10 change ideas
2. Tips and insights
3. Practical tools and templates

We hope you find them useful in your journey.



Akos Hoffer, CEO Perley Health

Was this field guide useful?

Tell us what you think by scanning the QR Code.

Complete the survey before May 1, 2026 for a chance to win one of four $25 gift cards!

You can always email us at centreofexcellence@perleyhealth.ca

Table of Contents

Background

Skin and wound care is a priority in long-term care (LTC). Older adults living in LTC are at elevated risk of skin breakdown due to age-related changes, increasing frailty, multiple chronic conditions, immobility, and nutritional challenges. Pressure injuries and other wounds are not only painful and distressing for residents but can also lead to serious complications such as infections, prolonged healing times, functional decline, and avoidable hospital transfers[1,2].

Despite the risks, skin and wound care in LTC is often complex and inconsistent. Staff must balance competing care demands. Additionally, variations in knowledge, skills, and assessment practices can result in missed opportunities for early intervention. Research has shown that pressure injuries and chronic wounds remain among the most common and costly adverse outcomes in LTC, placing both residents and care teams under significant strain[1,3].

At the same time, there is strong evidence that many wounds can be prevented, or their impact reduced through timely, standardized, and proactive care. Clear processes, shared accountability, and staff education make a measurable difference in resident outcomes[4,5]. When homes establish reliable approaches to skin health and wound management, they not only reduce harm but also improve quality of life and preserve dignity for residents.

This field guide was developed to address this need. It provides practical, evidence-informed strategies to help LTC teams strengthen skin and wound care practices in their own homes. By bringing together knowledge, tools, and lessons learned, the guide supports staff in delivering consistent, high-quality care that makes prevention and healing a shared responsibility across the care team.

Over 50% sustainable decrease in the average of worsening pressure injuries

Decrease Worsening Pressure Injuries

Perley Health's effective skin and wound care program decreased our home's average worsening pressure injuries by over 50%.

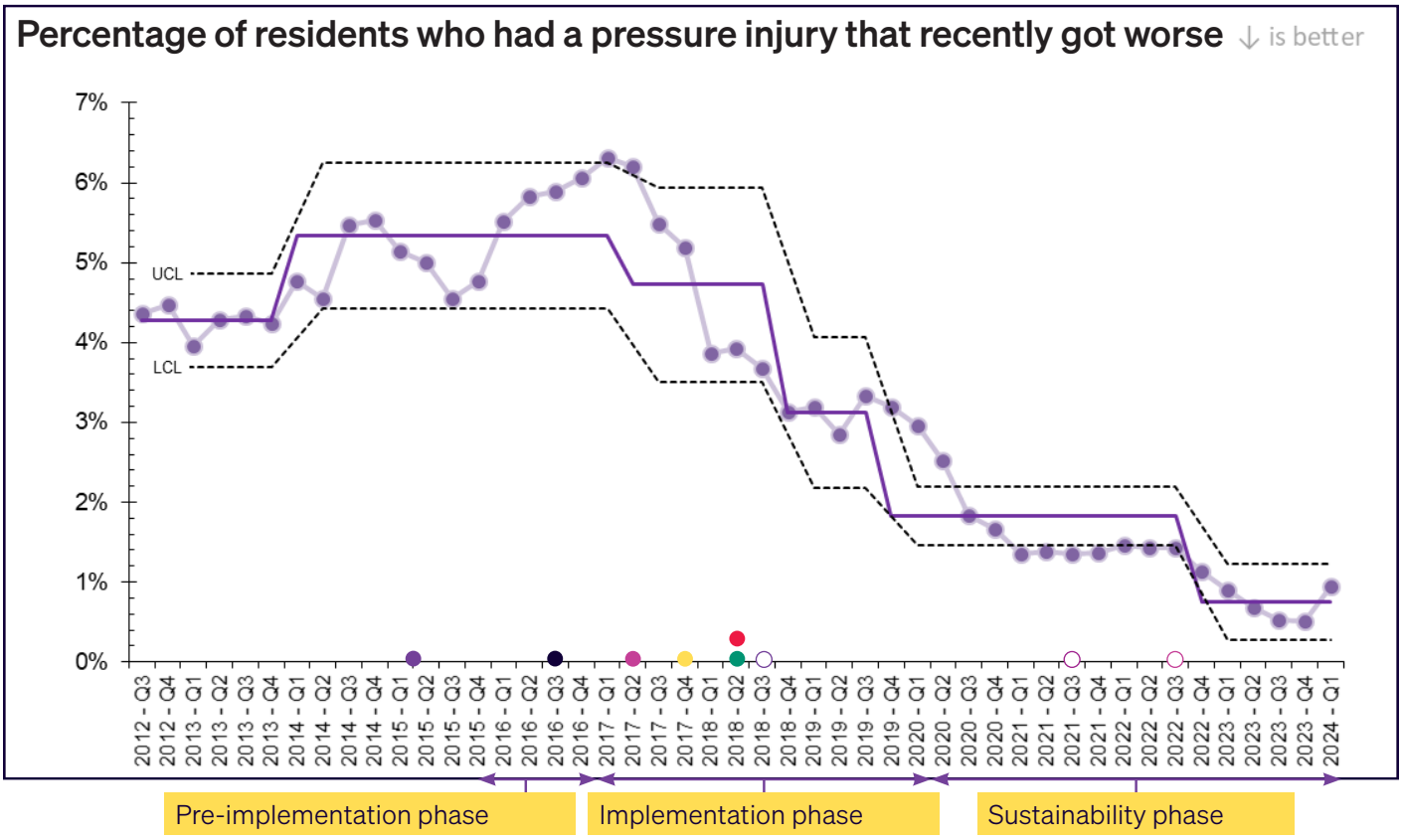


Figure 1. Percentage of residents who had a pressure injury that recently got worse

Interventions

- **Established quality improvement (QI) champion team**
- **Streamlined product supply**
- **Established interprofessional referrals**
- **Confirmed wound etiologies and validated pressure injury data**
- **Customized care plan library for wound etiologies**
- **Began enhancing documentation tools**
- **Hired in-house NSWOCC** (Nurse Specialized in Wound, Ostomy and Continence)
- **Standardized treatment scheduling**
- **Hired in-house SWAN** (Skin Wellness Associate Nurse)

Insight

It's a journey. Perley Health's data for worsening pressure injuries didn't change overnight. It took time, intentional focus, and continual re-evaluation. Eventually, your effort will build momentum and start delivering outcomes. **Keep going!**

"Pressure injuries serve as a key indicator of the overall quality and safety of healthcare organizations and facilities[4]." **– RNAO, 2016**

Over 50% sustainable decrease in the average of skin and wound infection rates

Reduce Infections

Perley Health's effective skin and wound care program decreased our home's skin and wound infection rate by over 50%.

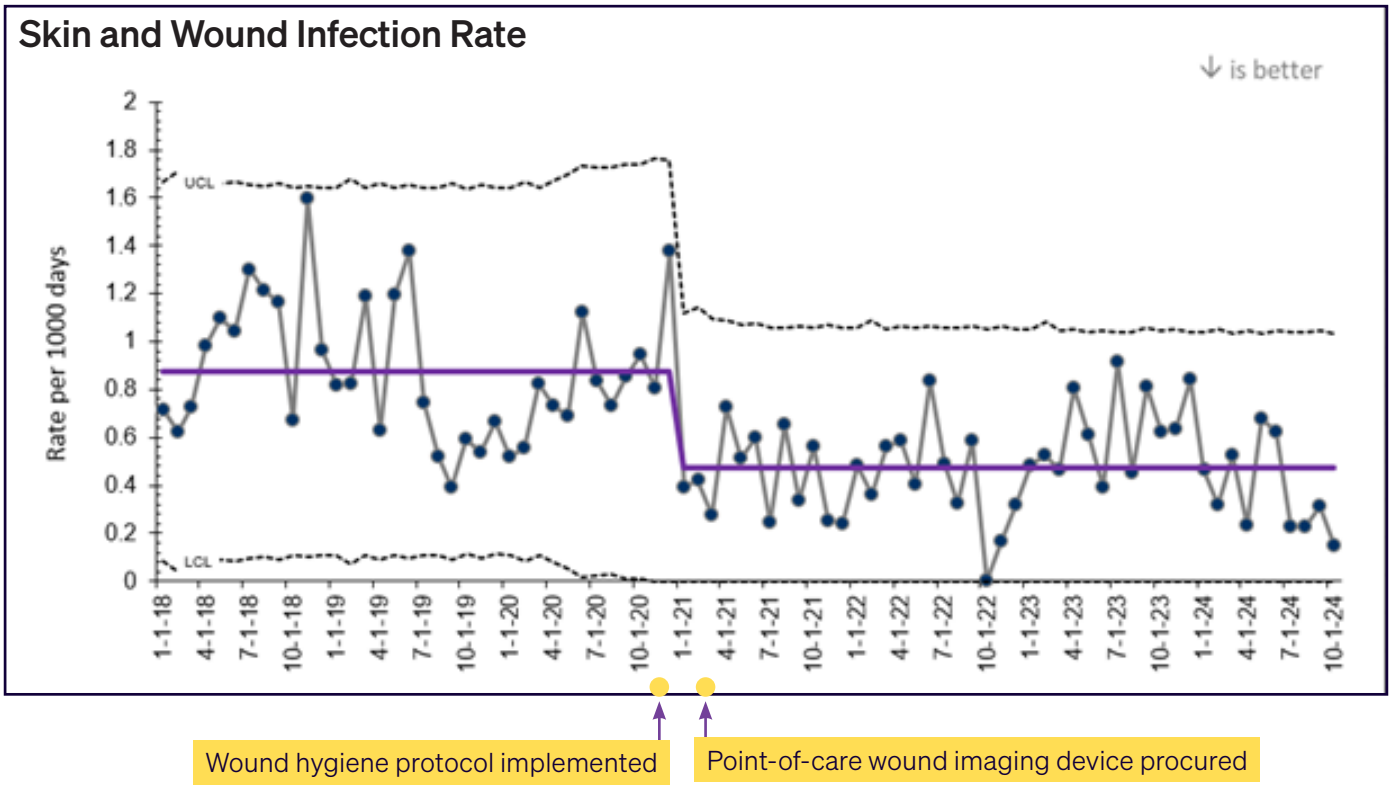


Figure 2. Skin and wound infection rate over time

"I know that Perley Health saved my life. I was in serious trouble when I arrived here. I had a long gash on my lower leg and two bedsores; the one on my coccyx was about the size of a grapefruit and the one of the upper part of my leg was eight centimetres deep. Both were infected and had reached bone."

Nicole Lafleche, Perley Health resident

"Deep and surrounding wound infections can cause tissue damage and pain to residents" – **RNAO, 2016**

Insight

The right leader(s) for the right results!

Our observed competencies of an effective Skin and Wound Care Program Lead, or complementary characteristics of co-leads, include:

- Specialized nursing training in skin and wound care.
- Expressive passion for skin and wound care.
- Familiar with governing long-term care legislation.
- Past quality improvement experience.
- Known and trusted by the interprofessional team.
- Holds influence with senior leaders and/or management.

Building an Engaged Team

Before you start, create a quality improvement team dedicated to steering the implementation of the skin and wound program.

Considerations for Planning Your Team.

Inclusivity: Build your team to include a diversity in:

- Skill set
- Knowledge areas
- Perspectives/opinions

Having diversity within the team enables stronger decisions, allows the development of better processes/tools, and helps build your champion network for the changes.

Impact: Consider including stakeholders who will be will impact, or be impacted by the changes, such as

- Residents
- Care Partners or other representatives of the residents
- Point-of-care staff
- Internal subject matter experts
- Leadership

Size: Think about how big the team needs to be for this project.

- Ensure you have enough people to strengthen discussion, support decision-making and distribute tasks. Less than five is probably not enough and more than ten is probably too many.
- You can always add or remove members of the team based on the work at any given time.

Ground rules: Once the team is made, it is important to establish ground rules for successful engagement. These may evolve over time and can include:

- Team values and code of conduct
- Project scope
- Key objectives and deliverable
- Team member responsibilities and role clarity

Tip

Have fun with it! Our "**S**kin and **W**ound **A**ssessment **T**eam" became known across the home as the **SWAT team**.

Keeping Residents and Families at the Center of Care

To build an effective, resident-centered skin and wound care program, the needs and perspectives of residents and their care partners must remain central[6].

Residents and care partners highlighted the following person-centered considerations as most important:

- Always speak to the resident first about their own health status and care, tailoring your communication to their cognitive abilities[6].
  - Engage care partners with expressed permission from the resident, or when appropriate for substitute decision making.
- Be intentional about involving residents and care partners in developing the plan of care for wound prevention and treatment.
- Provide education about the causes, stages, and treatment options for wounds and skin impairments in ways that are clear and accessible.
- Take extra time to explain the plan of care for wound healing. Residents and care partners often want to know:
  - How is the wound being treated?
  - Why was this treatment recommended?
  - What approaches have been tried before?
  - Why certain treatments may not be effective?
  - How is pain being managed?
- Use visuals such as wound photos (with consent) to help residents and care partners see progress over time.
- Identify the interprofessional team members involved in the plan of care. Ideally, each team member should connect directly with the resident and care partner to explain their role and planned interventions.
- Provide information about common interventions that residents and families may wish to better understand, such as:
  - Repositioning routines.
  - Pressure redistribution surfaces.
  - Protein and nutritional interventions.
  - Range-of-motion exercises.

Insight

The ideal structure of a skin and wound care program is not clearly outlined in the literature. Teasing out these practical components of the overall program made for a more comprehensive skin and wound care program in long-term care.

Know the Components of a Skin and Wound Care Program

At Perley Health, we implemented best practices from the literature to build an effective skin and wound care program for long-term care. What emerged in practice were four distinct but interrelated components to the program, see Figure 3. They influenced and built on one another while maintaining their own separate areas of focus and expertise.

Figure 3. Components of an effective skin and wound care program

10 Key Change Ideas for Improving a Skin and Wound Care Program

Here are **10 key** change ideas and actions that contributed to Perley Health's effective skin and wound program, see Figure 4.

The implementation of these change ideas was interrelated and tended to overlap and influence each other throughout the process, especially for those within the same component. The interventions are numbered for ease of reading but can be implemented in any order.

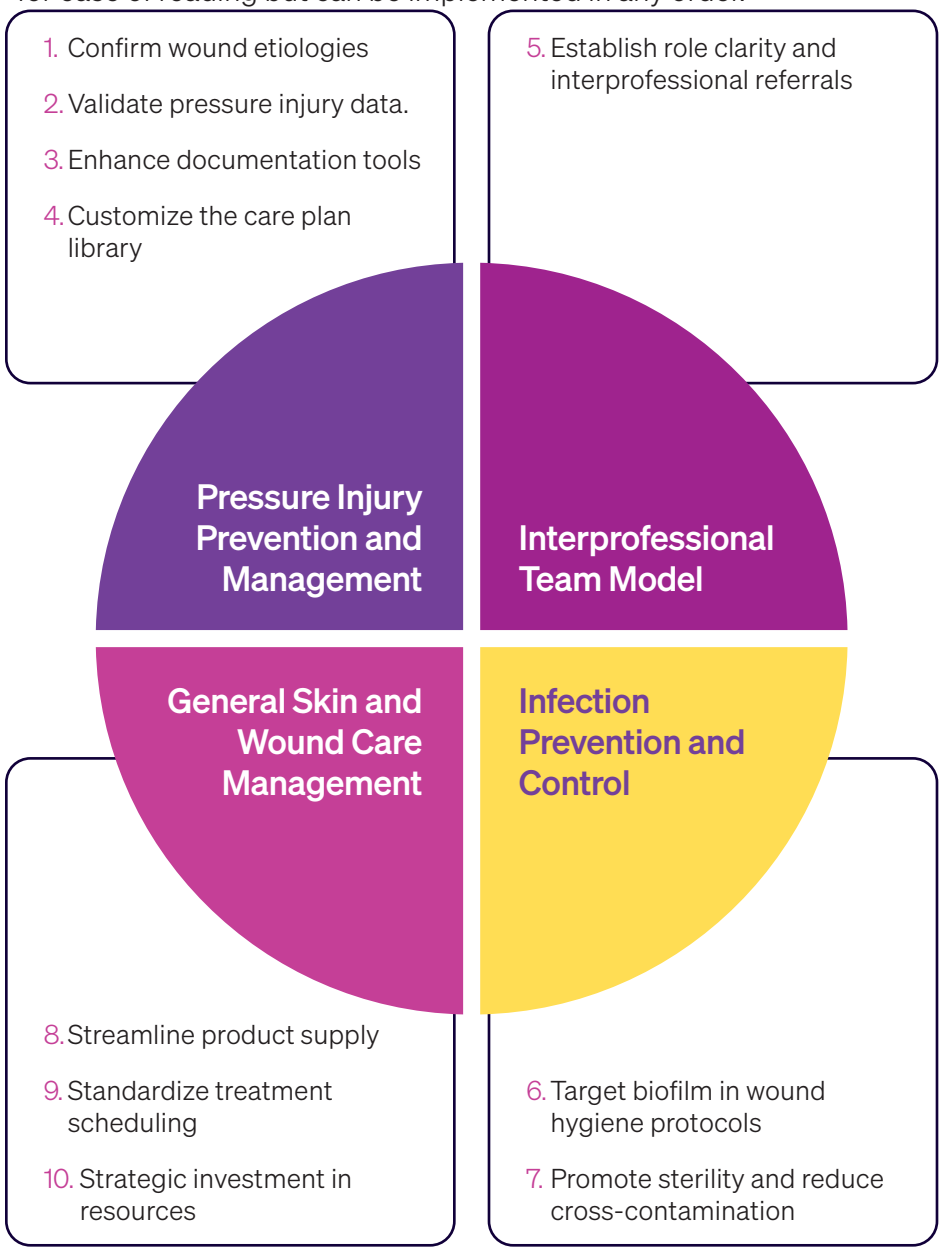


Figure 4. Ten key change ideas across four components of a skin and wound care program

Tip

Remember the process is not linear. Implementation activities will jump between components based on your home's existing processes and priorities.

Insight

These 10 change ideas had the biggest impact on success for our team, but they aren't the only changes we made.

To learn more details about our journey at Perley Health, reach out to our Knowledge Translation team at centreofexcellence@perleyhealth.ca.

1. Confirm Wound Etiologies

All pressure injuries are wounds, but not all wounds are pressure injuries.

Our improvement team suspected that the majority of documented wound etiologies within our home might be wrong. Since every wound type has its own set of recommended interventions and treatments, we needed to confirm what types of wounds we were caring for in the home.

Wound Etiology Audit Checklist :

Hire or assign one or two certified wound specialists or wound care champions to run the audits.

- Ensure they have specific training on wound etiology definitions.

Identify residents with documented wounds on the unit.

- Pull wound documentation reports from the medical records.

Validate your list with the regular unit nursing team and/or unit physician/nurse practitioner to ensure any, and all, undocumented wounds are reflected in the audit.

Conduct a chart review for each resident with a wound.

- Medical diagnosis
- Lab results and vital signs
- Resident mobility status
- Continence status
- Nutritional status
- Medication
- Interprofessional notes
- Current wound care orders
- Care plan

Systematically assess all existing wounds to determine the correct etiology of the wounds.

Notify unit nursing team of required care plan changes if etiology, interventions, or treatments are incorrect.

Set up a tracking system for ongoing monitoring of new and worsening wounds in your home.

Insight

Our lead auditor had the following credentials:

- Registered Nurse
- Graduate of a nationally recognized wound, ostomy, and continence program
- Nurse Specialized in Wound, Ostomy, and Continence Canada (NSWOCC) Certified

Tip

Sustain documentation accuracy by having all future suspected pressure injuries validated by a trained wound care champion(s) on an ongoing basis.

Toolkit

Our *Wound Etiology Guide* can help get you started. Access it in Appendix A.

2. Validate Pressure Injury Data

Compare the number of validated pressure injuries from your audit with the number of reported pressure injuries from your home's official quality data for pressure injuries (i.e., Resident Assessment Instrument Minimum Data Set [RAI MDS]).

Comparison	Implication	Potential Risks
Audit outcome is lower than the quality data.	Wounds are being overgeneralized as pressure injuries.	• Residents receiving the wrong treatments for their wounds, potentially delaying healing. • Mandatory reporting data on pressure injuries is inflated, harming organizational reputation.
Audit outcome is higher than the quality data.	Pressure injuries and risk of pressure injuries are going unrecognized.	• Residents living with untreated Pressure Injuries and/or increased risk of developing them. • Mandatory reporting data on pressure injuries is a misrepresentation, harming organizational integrity.

At Perley Health our actual pressure injury data was lower than our reported quality data, indicating that our team was overgeneralizing all wounds as pressure injuries. Our immediate actions were to:

- Correct the etiology documentation for each wrongly documented wound.
- Create a new interprofessional treatment plan for all miscategorized wounds.
- Educate point-of-care staff on the definition of a pressure injury.

This work is sustained by our certified wound specialist, whose responsibilities include:

- Reviewing weekly reports of newly documented wounds.
- Assessing all suspected pressure injuries to confirm the correct etiology.
- Providing treatment recommendations to the point-of-care team.
- Leading just-in-time training at the point of care for mistaken etiologies.

Definition of pressure injury

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue[7].

Insight

After correcting the wound etiologies, our quality indicators related to pressure injuries began to improve.

3. Enhance Documentation Tools

We created two new documentation tools to guide our point-of-care nursing team through the steps of a thorough skin and wound assessment for residents, including intervention options. They were co-designed with the care team and embedded into our electronic medical record.

- **Head-to-Toe Skin Assessment**
  - Guides nurse through an evidenced-informed, head-to-toe skin assessment.
  - Completed on admission, quarterly, on return from hospital, on return from leave of absence, and with a change of condition.
- **Weekly Wound Assessment**
  - Integrates the standardized Pressure Ulcer Scale for Healing (PUSH) Tool[8].
  - Guides a nurse through an evidenced-based assessment of a wound.
  - Completed weekly for every wound.

We used validated assessment tools where possible, but often had to tailor them to our unique environment and context.

Tip

To increase completion rates of the new documentation tools, we leveraged current workflows:

- Prompted the *Head-to-Toe Skin Assessment* in three well-established, existing processes:
  - Admission checklist
  - RAI MDS assessment schedule
  - Return from hospital checklist
- Linked or replaced existing documentation progress notes with the new documentation checklists.

Toolkit

Why reinvent the wheel? Access our *Head-to-Toe Skin Assessment* and our *Weekly Wound Assessment* in Appendix B and Appendix C, respectively.

Insight

Making a documentation tool:

Best practice recommendations can rarely be taken directly from the literature and included in a documentation tool.

Work through the evidenced-based recommendations with your interprofessional quality improvement team to make your own tools that are tailored to current resources, workflow, and processes.

Include feedback from end users, which in our case were nurses, to ensure value of using the tools.

4. Customize the Care Plan Library

Make it easier for people to do the right thing: integrate wound care pathways and standardized language into your organization's custom care plan library.

How?

- Create customized, preset care plan focuses, goals, and interventions for each separate wound etiology.
- Base the customized care plan items on best practices, internal processes, and policies.

Why?

- To ensure an optimal care plan for each wound etiology.
- To force function care pathways for specific wound etiologies.
- To make the care plan interprofessional and holistic.

Table 1, below, is an example from Perley Health's custom care plan library for pressure injuries. Care professionals can customize the sections marked 'specify'.

Focuses	Etiologies	Goals	Interventions
Pressure injury (must have an external source of pressure), location (specify) with the following contributing factors (specify)	Cognitive impairment Friction and pressure Impaired mobility Incontinence Altered sensation Medical condition/ diagnosis (specify) Non-compliance with therapeutic regime Nutritional deficit Obesity Positioning devices/ restraints/personal assistive service devices (PASD)	Healable Non-healable maintenance (Specify: Stabilize wound, Prevent new wounds, Eliminate odour, Control pain, Infection prevention, Advanced dressing, Lessen dressing changes as palliative care occurs)	Encourage food, fluids, and supplements as per orders Reduce contributing factors in the environment (specify) Use protective devices for skin (specify) Refer to registered dietitian for nutrition assessment for pressure injury Cleanse and dress Refer to SWAT Team Use supportive surfaces where applicable (specify) Turn and reposition with skin care every two hours Completely offload heels in all positions Refer to occupational therapy (OT)

Table 1. Excerpt from Perley Health's care plan library for pressure injuries.

Insight

Include the interprofessional team when creating the care plan library.

Toolkit

We made it easy for you. Access our expanded custom care plan library for wound etiologies in Appendix D

5. Establish Role Clarity and Interprofessional Referrals

Intentionally designing an interprofessional skin and wound care program was important to our team because:

1. It was recommended in the RNAO Best Practice Guideline, "Assessment and Management of Pressure Injuries for the Interprofessional Team[4]
2. Our governing long-term care legislation required it.[9]
3. We saw a more holistic approach to wound prevention and healing.

Building an Interprofessional Program Checklist

Identify which disciplines have accountabilities or tasks related to skin and wound care.

Clarify the role of every discipline in the prevention and management of skin and wounds.

Map out a process for interprofessional referrals and communication between the disciplines.

Prompt for key tasks and actions in relevant documentation tools and the custom care plan library .

Communicate and educate all the disciplines on the following:

- Importance of an interprofessional program.
- Role clarifications.
- Updated process and communication plan.

Here is how we defined our interdisciplinary roles in skin and wound management at Perley Health:

Personal Support Workers • Bedside monitoring of skin conditions. • Reporting changes in skin conditions.	**Registered Nurses and Registered Practical Nurses** • Routine wound care assessment. • Routine dressing changes. • Referrals to interprofessional team.
Certified Nurse Specialists (i.e NSWOCC*/SWAN)** • Assessment of complex wounds. • Dressing and care recommendations. • Point-of-care education. • High intensity completions (NSWOCC only). *Nurse Specialized in Wound, Ostomy and Continence Canada Certified ** Skin Wellness Associate Nurse	**Occupational Therapists and Occupational Therapist Assistants** • Seating and positioning assessments. • Pressure redistribution surface recommendations. • Pressure reduction recommendations. • Skin protection equipment recommendations.

Dietitians • Tailored nutritional assessments. • Nutrition and hydration recommendations.	**Infection Prevention and Control Team** • Surveillance of skin and wound infections. • Recommendation in infection prevention and control, including legislation requirements.
Physicians & Nurse Practitioners • Diagnosis of routine skin conditions. • Routine medical treatments. • Referrals to the dermatologist. • High intensity completions.	**Dermatologist** • Diagnosis of complex skin conditions. • Specialized medical treatments.

Create an Easy Interprofessional Referral System

We created an interprofessional referral system that is embedded within our electronic medical record platform. Benefits of this approach include:

- **Accessibility:** Referral pages are easily accessed by all authorized members of the resident's care team, at any time.
- **Prompting:** Referrals are prompted by our documentation tools within the electronic medical record platform.
- **Streamlined:** It is easy to navigate from the referral prompt to the referral page, decreasing time and risk of forgetting to complete.
- **Easy tracking:** Incoming referrals are easily tracked in the system and instantly recorded as part of the official health record.
- **Convenient:** Immediate access to the rest of the resident's electronic chart for the individual receiving the referral.
- **Customizable:** Each discipline designed their own referral page to meet their needs so they can easily update as needed.

An Interprofessional Approach to Preventing Pressure Injuries

When residents are admitted, use validated tools, such as the Pressure Ulcer Risk Score (PURS), to identify their individual risk of developing new pressure injuries[10].

The interprofessional care team should collaborate to create a pressure injury prevention care plan. The chosen interventions will depend on the resident's individualized risks, but common strategies include:

- Turning and repositioning every 2 hours.
- Using moisture reduction strategies and tools, such as frequent incontinence care, skin barrier creams, and moisture-wicking garments, fabrics, and/or mattress overlays.
- Optimizing resident mobility.
- Ensuring surfaces provide the appropriate pressure redistribution.
- Meeting the nutritional needs of the resident.

Toolkit

Need an example? See our interprofessional skin and wound care program policy in Appendix E.

Insight

What is biofilm?

Complex and encased microbial communities that cause persistent bacterial infections.[12]

Tip

Collaboration is key!

Collaborate with your Infection, Prevention, and Control (IPAC) Lead and/or Team. Why?

- They have surveillance data on skin and wound infections.
- They are familiar with infection trends and challenges within your home.
- They have specialized knowledge and expertise in preventing infections.

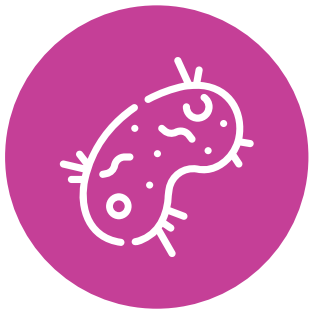
Insight

Understand your infections.

To reduce infections, it is important to understand the underlying causes. Our IPAC team identified an increasing trend in wound infections because of their robust surveillance program. This triggered more detailed audits and interprofessional meetings to find the practice gaps, leading to the two change ideas outlined on this page.

Perley Health's IPAC surveillance program is not detailed within the scope of this document, but if you would like to learn more, email us at: centreofexcellence@perleyhealth.ca.

6. Target Biofilm in Wound Hygiene Protocols



Addressing infections as part of a skin and wound care program is important because deep and surrounding wound infections can cause tissue damage and pain to residents[4]. It is also important for decreasing the use of antibiotics.

Since 80% of infections are caused by biofilm[11], we switched to a wound cleanser that contains a surfactant and antimicrobials.

- **Surfactant:** Breaks down the biofilm and target its source.
- **Antimicrobials:** Target bacteria and slows the rebuild of biofilm.

Toolkit

A quick win! Access our simple wound hygiene protocol, which supported a 56% drop in the average skin and wound infection rates at Perley Health in Appendix F. It also includes the NERDS and STONEES[13] tool, two mnemonics to help healthcare providers identify deep tissue infection in wounds.

7. Promote Sterility and Reduce Cross-Contamination

We observed our current practices in wound care treatments at the point of care and identified key areas of risk for wound infections.

To reduce cross-contamination, we took the following actions:

1. Removed vectors.
   - Discontinued any wound care carts and/or bins, as they carry pathogens
2. Promoted sterility.
   - Purchased gauze in individual sterile packages instead of in sleeves of clean gauze in order to prevent contamination.
   - Encouraged use of products as they are designed (single use). Once the product is opened, do not reuse.
3. Created clean treatment surfaces.
   - Supplied clean procedural pads to catch debris under wound treatments instead of clean towels, as they might be contaminated.

8. Streamline Product Supply

We recommend offering a limited, but carefully curated, selection of readily available skin and wound products at the point of care. We found that fewer options for the care team supported easier, faster, and safer bedside decisions. They also decreased wasted product.

How to streamline product supply.

1. Review your wound etiology data and identify common etiologies in the home.
2. Review the skin and wound care products on the market, and don't be afraid to reach out to multiple vendors.
3. Engage key stakeholders, like point-of-care staff, residents, and care partners, in the product evaluation/selection.
4. Consider partnering with a skin and wound care product vendor for a suite of skin and wound supplies.
5. Develop a clear reordering process that limits reordering accountability to one or two individuals.
6. Allocate a room on each unit for easy point-of-care access to the supplies.
7. Organize the supplies in the room by size and shape in a way that ensures accessibility.
8. Remove any extra bins, carts, or other makeshift "storage spaces" where skin and wound supplies can be forgotten and left to expire.

Insight

Having a clear inventory management process:

- Sets clear accountability for the ordering of skin and wound care supplies.
- Ensures the right number of products are available when needed.
- Reduces "hoarding" of supplies by staff in unknown places.

Overall, staff save time when they are collecting supplies for providing skin and wound care.

Insight

Consider the potential benefits of exclusively partnering with a single vendor.

1. Planned product lines.
2. Loyalty discounts.
3. Access to free education.

9. Standardize Treatment Scheduling

Scheduling skin and wound treatments get complicated when it involves many different care providers over multiple shifts and units.

We established a standardized approach to scheduling ongoing skin and wound assessments and treatments.

Checklist for Standardizing Treatment Scheduling

Observe the workflow and learn the preferences of care providers who schedule treatments.

Choose *one*, organizationally accessible location for scheduling (we chose the electronic Treatment Administration Record [TAR]).

Create customizable text templates for care providers to use while scheduling treatments in the TAR.

Bundle scheduling of skin and wound treatments with other well-established care schedules. For example, we linked routine wound dressing changes with bath day schedules.

Case Study

A resident is due for a scheduled wound care treatment on Unit A. The scheduled reminder is posted in the nursing communication book, as per common practice on Unit A. Today, a casual nurse from Unit B is covering. Unit B doesn't typically use a nursing communication book; they always schedule treatments in the Treatment Administration Record. As a result, the casual nurse does not immediately see that a treatment is due and plans her day without this task. When the resident asks about the treatment near the end of the shift, the nurse scrambles to complete it, feeling frustrated. When the treatment instructions are finally found in the communication book, it simply reads, "Change dressing to wound until healed."

1. What are the problems in this scenario?
2. What potential risks to the resident and nurse are present?
3. Which systemic scheduling strategies could help improve care?

*Access our case study worksheet and answer key in Appendix G.

Insight

Talk about confusing!
Prior to standardizing our treatment schedules, our team often scheduled treatment reminders in too many different places:

- TAR
- 24-hour communication book
- Nursing communication book
- Unit calendar
- Progress notes
- Email calendar

Tip

We chose to locate all skin and wound treatment schedules in the electronic TAR because:

- It tracks task accountability through documentation.
- All our nurses have access and know it well.
- Most other types of treatments are also scheduled there.
- Reports are easy to pull for ongoing audits and tracking.

A little note on customizable text templates for scheduling treatments.

Implementing customizable text templates made treatment scheduling reminders:

- More readable and comprehensible.
- More effective at reminding staff of the required treatment.
- More consistently written across the home.
- More accurate and contained the required information.
- Faster and easier to document.

Figure 5 shows examples of the customizable text templates we use for three common wound care treatment scenarios.

Monitor Dressing Order	**Template:** (Location) - (Type of Wound) Monitor Dressing to ensure that dressing is dry and intact **Recurrance:** Every 12 hours
Weekly Wound Assessment	**Template:** (Location) - (Type of Wound) Weekly wound assessment with picture **Recurrance:** (Schedule Specific Day of the Week)
Dressing Order	**Template:** (Location of wound) - (Type of Wound): Cleanse with (cleanser) and dress with (specify dressing). Change dressing (enter frequency) and PRN **Recurrance:** (Schedule specific day(s) of the week)

Black: Scripted text in the template.

Green: Customizable text for specific details.

Figure 5. Examples of customizable text templates for skin and wound care treatments

Definition

A text template for scheduled treatments is a preset script for scheduling treatments with the ability to be customized with specific details.

10. Strategic Investment in Resources

Building an effective skin and wound care program requires thoughtful investment into key resources, such as expertise, equipment, and program priorities. At Perley Health, we made several key investments that contributed to the successful implementation and sustainability of our program.

While every organization's circumstances and budgets differ, we share these examples to help inspire creative and achievable ideas for your team's unique quality improvement efforts.

Invest in skin and wound care expertise

We hired certified nurse specialists in roles dedicated to enhancing the skin and wound care program, specifically Nurse Specialized in Wound, Ostomy and Continence in Canada (NSWOCC) and Skin Wellness Associate Nurse (SWAN).

Alternatively, homes can consider consulting services or building capacity in a skin and wound care champion.

Invest in medical expertise:

We established a consulting arrangement with a dermatologist who comes onsite for complex medical cases.

Alternatively, homes can consider telehealth options or working with primary care physicians and/or nurse practitioners with enhanced skills in skin and wound care.

Invest in therapeutic equipment:

We prioritized pressure redistribution equipment, therapeutic support surfaces for beds/chairs and offloading equipment to help prevent and heal pressure injuries, maximize comfort, and facilitate engagement and independence.

Alternatively, homes can prioritize key items, like wedges, mattresses, and offloading boots within their budgets.

Invest in interdisciplinary collaboration:

We have occupational therapists, occupational therapy assistants, dietitians, and nurse practitioners as part of our permanent care team with offices onsite for easier communication, teamwork, and collaboration.

Alternatively, homes can consider consulting with external clinics or hiring temporary contracts.

Invest in specialized technology:

We leverage technology to enhance our assessments and facilitate more effective treatment plans.

- **Ankle-brachial index (ABI) toolkit:** Measures severity of peripheral artery disease to inform goals of care and candidacy for compression.
- **Point-of-care wound imaging device:** Detects the presence and location of elevated bacterial load and digital wound measurements.
- **Vacuum Pump:** Supports for negative pressure wound treatment to promote wound healing.

Alternatively, homes can consider renting or sharing diagnostic and imaging tools with other local organizations.

Invest in educational tools:

We used wound care task trainers and tools that simulate the human anatomy and wound types to create engaging and experiential learning opportunities for the team.

Alternatively, homes can explore accessing training resources though partnerships with learning institutions or other local organizations.

Insight

Did you know? In Ontario, Canada, NSWOCC and/or nurse practitioners are authorized to support completion of government reimbursement forms for the High Intensity Needs Fund for wound care supplies. This made the application writing process significantly easier and more accessible at Perley Health.

Bonus Idea: Targeted Ongoing Education

Establish an ongoing education plan for your interprofessional, team related to skin and wound care. Although education on its own is not an effective change strategy, when combined with other strategies outlined in this field guide, it led to sustainable change.

Consider blending multiple adult learning strategies into your curriculum in order to appeal to more people and reinforce the messaging. Some strategies include:

- **Didactic:** In-services, demonstrations, formal courses.
- **Experiential:** Simulations, case studies, hands-on practice, learning games.
- **Collaborative:** Coaching, mentoring.
- **Self-Directed:** E-modules, videos, job aids.

To maximize impact, match your education to the right timing:

- **Orientation:** Best for foundational information every new hire should know before starting work.
- **Routine:** Best for information that staff need regular refreshers on.
- **Just-in-time:** Best for urgent or new information staff need to apply immediately.

Toolkit

Make learning practical and fun! Access the facilitator's guide to the "Skin and Wound Care Carnival" training, in Appendix H. It's a 15-minute micro-education done right on the unit with registered nurses, registered practical nurses and personal support workers. Participants randomly choose one of four hands-on carnival activities to complete:

- **Tubigrip Challenge:** Practice sizing and applying of Tubigrip.
- **Wound Hygiene Challenge:** Practice wound cleansing and biofilm removal.
- **Inflammation versus Infection:** Distinguish between inflamed or infected wounds.
- **Moisturizer, Barrier, or Dressing Cream Challenge:** Match the right cream with the skin impairment.

Was this field guide useful?

Tell us what you think by scanning the QR Code.

Complete the survey before May 1, 2026 for a chance to win one of four $25 gift cards!

You can always email us at centreofexcellence@perleyhealth.ca

Reference List

1. Canadian Institute for Health Information. (2022). Continuing care reporting system (CCRS) profile: Pressure ulcers in long-term care. Canadian Institute for Health Information.
2. National Pressure Injury Advisory Panel. (2021). Pressure injury prevalence and incidence: A review of the literature. National Pressure Injury Advisory Panel.
3. Health Quality Ontario. (2017). Quality standards: Pressure injuries. Health Quality Ontario.
4. Registered Nurses' Association of Ontario. (2016). Assessment and management of pressure injuries for the interprofessional team (3rd ed.). Registered Nurses' Association of Ontario.
5. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, & Pan Pacific Pressure Injury Alliance. (2019). Prevention and treatment of pressure ulcers/injuries: Clinical practice guideline. EPUAP/NPIAP/PPPIA.
6. Ontario Association of Residents' Councils. (2025). Ask a resident first – Resident engagement in long-term care home operations and decision-making [Video]. YouTube. https://www.youtube.com/watch?v=74IA6vnJFEU
7. National Pressure Injury Advisory Panel. (n.d.). Understanding pressure injury etiology. https://internationalguideline.com/etiology
8. National Pressure Injury Advisory Panel. (2025). Pressure ulcer scale for healing (PUSH tool). https://npiap.com/page/PUSHTool
9. Government of Ontario. (2021). Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1. https://www.ontario.ca/laws/statute/21f39
10. Poss, J., Jutan, N., Hirdes, J. P., Fries, B. E., Morris, J. N., Teare, G. F., & Reidel, K. (2010). Development of the interRAI pressure ulcer risk scale (PURS) for use in long-term care and home care settings. BMC Geriatrics, 10(67). https://doi.org/10.1186/1471-2318-10-67
11. Jamal, M., Ahmad, W., Andleeb, S., Jalil, F., Imran, M., Nawaz, M. A., Hussain, T., Ali, M., & Rafiq, M. (2018). Bacterial biofilm and associated infections. Journal of the Chinese Medical Association, 81(1), 7–11. https://doi.org/10.1016/j.jcma.2017.07.012
12. Zhao, A., Sun, J., & Liu, Y. (2023). Understanding bacterial biofilms: From definition to treatment strategies. Frontiers in Cellular and Infection Microbiology, 13, 1137947. https://doi.org/10.3389/fcimb.2023.1137947
13. Woo, K. Y., & Sibbald, R. G. (2009). A cross-sectional validation study of using NERDS and STONEES to assess bacterial burden. Ostomy Wound Management, 55(8), 40–48. https://pubmed.ncbi.nlm.nih.gov/19717855

Acknowledgments

We would like to sincerely thank and highlight the excellent care that our dedicated staff and physicians provide to Perley Health's Seniors and Veterans every day.

Perley Health's skin and wound care program is supported, in part, through the generosity of donors who all share a commitment to transforming care for Seniors and Veterans.

In the creation of this field guide, we would also like to thank the project participants who contributed to the project's planning, consultation, reviewing, and additional engagement.

- Atul Jaiswal, Collaborative Reviewer, Perley Health
- Amanda Bowen, Collaborative Reviewer, Perley Health
- Danielle Sinden, Collaborative Reviewer, Perley Health
- Emily Kewell, Collaborative Reviewer, Perley Health
- Heather MacLeod, Collaborative Reviewer, Provincial Geriatrics Leadership Ontario
- Jennifer Behun, Collaborative Reviewer, The Registered Nurses' Association of Ontario
- Khristina Soares, Collaborative Reviewer, Perley Health
- Linda Hunter, Family Partner, Perley Health
- Pierre Richard Saintable, Collaborative Reviewer, Bruyère Health
- Rachel Debling, Editor
- Rachel Gibson, Collaborative Reviewer, Perley Health
- Rebecca McEwen, Collaborative Reviewer, Frontenac County
- Stephanie Kim, Collaborative Reviewer, Perley Health
- Susan Shea, Collaborative Reviewer, Perley Health
- Tom Lilly, Communications, Perley Health
- Wendy Nicklin, Family Partner, Perley Health

Wound Etiology Guide for Common Wounds in LTC

Category	Etiology	Definition	Typical Characteristics
Pressure injury: Localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.	Stage 1	Mildest stage of a pressure injury; non-blanchable erethyma of intact skin due to capillary compromise	• Non-blanchable erythema of intact skin
	Stage 2	Partial thickness loss of skin with exposed dermatitis; epidermis has been compromised or removed	• Superficial wound • No slough
	Stage 3	Full thickness loss of skin; epidermis and dermis have been compromised or removed	• Full thickness wound • Adipose tissue is exposed • Slough and/or eschar possible • Undermining and tunnelling possible
	Stage 4	Full thickness loss of skin with underlying structures involved	• Full thickness wound • Fascia, muscle, tendon, ligaments, cartilage, and/or bone are exposed
	Deep tissue injury	"Injury from intense and/or prolonged pressure and shear forces at the bone-muscle interface; may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss"	• Intact or non-intact skin • Persistant non-blanchable deep red, maroon, or purple discolouration • Dark wound bed or blood-filled blister possible • Discolouration may vary in darkly pigmented skin
	Unstageable	Pressure injury completely covered with eschar or slough, so that the depth of the base of the wound cannot be visualized or staged	• Eschar or slough covering the entire wound bed
Moistur-associated skin damage: Injury to skin caused by repeated, or sustained, exposure to moisture	Incontinence-associated skin damage	Inflammation of skin cause by prolonged and recurrent contact with urine and/or stool to the perineal or perigenital area.	• Partial thickness wounds • Pink wound bed • Indistinct and macerated wound edges • Located on both sides of a skin fold, giving a mirrored appearance.
	Intertrigo	Inflammation of the skin caused by moisture, bacteria, or fungi in the folds of the skin	
	Peristomal moisture associated skin damage	Inflammation of skin caused by prolonged and recurrent contact with stomal output.	
	Periwound moisture associated skin damage	Inflammation of the skin caused by recurrent contact with wound exudate	
Diabetic foot ulcers: Ulcers experienced by people living with diabetes	Diabetic foor ulcers	All skin impairments present below the ankle on someone who is diabetic; even if pressure is a contributing factor, due to underlying neuropathy, the wound etiology is a diabetic foot ulcer	• Partial or full thickness wound • Wounds vary in shape and size

Appendix A

Category	Etiology	Definition	Typical Characteristics
Vascular ulcers: Ulcers caused by venous and/or arterial insufficiency	Venous ulcer	Ulcer caused by venous insufficiency; venous valves are not functioning properly	• Shallow, red wound bed • Maceration, crusting, or scaling present • Moderate to heavy exudate • Located between knee and ankle
	Arterial ulcer	Ulcers caused by peripheral artery disease; arterial blood flow is partially or completely blocked	• Small, round, and appears punched out • Necrotic or pale wound bed • Minimal to no granulation tissue • Minimal exudate • Located on ankle, distal foot, and toes
	Mixed vascular ulcers	Wound caused by a mix of venous and arterial insufficiency	• Combined characteristics of both venous and arterial ulcers
Acute wounds: Wounds that happen suddenly, traumatically, or surgically, as opposed to developing over time	Friction injury	Injury caused by a mechanical force exerted on the skin	• Round, partial thickness wound • Pink wound bed • Can appear as a blister
	Skin tears	Traumatic wound caused by mechanical forces, including removal of adhesives; severity may vary by depth not extending through the subcutaneous layer*	• Partial thickness skin loss • **Type 1:** No skin loss, linear, or flap tear which can be repositioned to cover the wound bed* • **Type 2:** Partial flap loss which cannot be repositioned to cover the wound bed * • **Type 3:** Total flap loss exposing the entire wound bed*
	Surgical wounds	Wounds created as a result of a surgical or medical procedure	• Often a linear wound • Varies depending on procedure

* definition taken directly from reference. References:

1. International Skin Tear Advisory Panel (ISTAP) (2023) ISTAP Skin Tear Classification [URL: skintears.org/resources].

2. Wound, Ostomy and Continence Nurses Society (2016). In D.D & L.M Editor (Eds). *Core Curriculum Wound Management*, Wolters Klewer

3. National Pressure Ulcer Advisory Panel Website [URL: www.npiap.com]

Head-to-Toe Skin Assessment

Part A - Assessment

1. Are there any changes in skin temperature? (Compare symmetrical body parts for differences.)
   Yes No
   a. If yes, describe:

2. Are there any changes in skin colour? Yes No
   a. If yes, describe:

3. Does the skin have the right balance of moisture? Yes No
   a. If no, describe:

4. Does the skin have a normal skin turgor finding? Yes No
   a. If no, describe:

5. Is the skin intact? Yes No
   a. If no, describe:

6. Is there any oral mucosa breakdown? Yes No
   a. If yes, describe:

7. Any other problems

Part B - Wounds

1. Does the resident have any wounds? Yes No
   a. If the resident has a wound, please make sure there is a weekly wound assessment scheduled for each wound.

Weekly Wound Assessment (including PUSH Tool 3.0)

Section A: Reason

1. Reason for assessment

   Initial assessment

   Routine assessment

   Scab assessment

> **Note:** At Perley Health, this assessment is digital and uses a "show/hide" functionality. Depending on the answer of question one, different sections appear.
>
> - Selecting "Initial assessment" opens sections **B, C & D**
> - Selecting "Routine assessment" opens sections **B & C**
> - Selecting "Scab assessment" opens sections **D**

Section B: Wound

1. Please complete one assessment per wound every week. Take a picture of the wound and upload it to the electronic medical record.
2. What is the location of the wound?
3. What are the specific measurements of the wound? Include length, width, and depth.
4. What is the wound type?

   Diabetic foot ulcer

   Vascular ulcer

   Acute wound

   Pressure injury

   Moisture-associated skin damage

   Other

   Unknown - Skin and Wound Assessment Team referral required.

Section C: Assessment (PUSH Tool 3.0)

1. Select the wound's corresponding size.

   Length x width = 0

   Length x width = <0.3 sq cm

   Length x width = 0.3 - 0.6 sq cm

   Length x width = 0.7 - 1 sq cm

   Length x width = 1.1 - 2 sq cm

   Length x width = 2.1 - 3 sq cm

   Length x width = 3.1 - 4 sq cm

   Length x width = 4.1 - 8 sq cm

   Length x width = 8.1 - 12 sq cm

   Length x width = 12.1 - 24 sq cm

   Length x width = >24 sq cm

2. Select the wound's exudate amount.

   None

   Light

   Moderate

   Heavy

3. Select the option that best describes the wound's tissue type.

   Closed

   Epithelial tissue

   Granulation tissue

   Slough

   Necrotic tissue (eschar)

4. What is the resident's pain level during the assessment?:

5. Complete NERDS and STONEES below after the wound has been cleansed.

5a. Check for NERDS (any three or more NERDS indicates high superficial bacterial infection – consider A topical antimicrobial product for a two week challenge). Check all the NERDS that apply.

   Non-healing: Wound that is not 20-40% smaller in four weeks

   Exudative wound: Increase in wound exudate or more than 50% of dressing is stained with exudate.

   Red and bleeding: Wound bed tissue is bright red, or tissue bleeds easy with gentle manipulation.

   Debris: Presence of discolored granulation tissue, slough, or necrotic tissue.

   Smell: Unpleasant or sweet, sickening odour.

   None of the above.

5b. Check for STONEES (any three or more of STONEES indicates a high bacterial infection in the deep compartment – contact physician or nurse practitioner and consider systemic antibiotics +/- topical antimicrobial dressing). Check all the STONEES that apply.

   Size: An increased wound size may be due to deeper tissue damage caused by bacteria, the cause of the wound not being treated, or a local or systemic cause.

   Temperature: Infection should be suspected if there is a greater than three degree temperature difference between the two mirror image sites (e.g. right and left heal).

   Os: Osteomyelitis should be suspected if you can probe to exposed bone or bone is visible.

   New areas of breakdown.

   Erythema /edema.

   Exudate: Increase in wound exudate.

   Smell: unpleasant or sweet sickening odour.

   None of the above

6. Confirm the wound status:

   No infection.

   Superficial (three or more NERDS).

   Deep infection (three or more of STONEES).

7. Note any additional comments about the wound or periwound:

8. Note any actions taken (dressing change details, referrals sent, etc.).

Section D: Initial

1. Is a dressing order put in the Treatment Assessment Record (TAR)? Yes No
2. Is a dressing monitoring order put in place in the TAR? Yes No
3. Is a weekly wound assessment order put in place in the TAR? Yes No
4. Was the resident or their power of attorney (POA) notified, their skin impairment care plan discussed? Yes No
5. How was the attending physician notified about skin impairment?
   - Physician communication board.
   - Phone call.
   - In person.
6. Was the unit manager notified about the skin impairment? Yes No
7. Additional comments:

8. Has a referral to the registered dietitian been completed? (Mandatory). Yes No

Section E: Scab

1. Is the scab dry? Yes No
2. Describe peri-scab skin:
   - Pink or normal for ethnic group
   - Erythema/edema
3. Additional comments about the scab or peri-scab (e.g. actions taken, etc.):

Note:

1. This tool is tailored to the Perley Health process. It can be altered to meet the needs of any organization
2. We found it helpful to include a subsequent section (not shown here) that allows users to directly update the resident's care plan, based on the outcome of this assessment.

Perley Health's Custom Care Plan Library for Wound Etiologies

Focuses	Etiologies	Goals	Interventions
Pressure injury (must have an external source of pressure), location (specify) with the following contributing factors (specify):	Cognitive impairment Friction and pressure Impaired mobility Incontinence Altered sensation Medical condition/ diagnosis (specify) Non-compliance with therapeutic regime Nutritional deficit Obesity Positioning devices/ restraints/personal assistive service devices (PASD)	Healable Non-healable, maintenance (specify: stabilize wound, prevent new wounds, eliminate odour, control pain, infection prevention, advanced dressing, lessen dressing changes as palliative care occurs)	Encourage food, fluids, and supplements as per orders Reduce contributing factors in the environment (specify) Use protective devices for skin (specify) Refer to registered dietitian for nutrition assessment for pressure injury Cleanse and dress Refer to SWAT Team Use supportive surfaces where applicable (specify) Turn and reposition with skin care every two hours Completely offload heels in all positions Refer to occupational therapist (OT)
Potential for/impaired skin integrity related to (specify):	Impaired mobility Incontinence Injury (specify) Nutrition deficit Obesity Positioning devices/ restraints/personal assistive service devices (PASD) Medical diagnosis (specify)	To heal skin impairment To protect skin from (specify)	Clean neoprene sleeves as per schedule (specify location and schedule) Use supportive surfaces where applicable (specify) Turn and reposition with skin care every two hours Completely offload heels in all positions Refer to occupational therapist (OT) Refer to dietitian if nutritional intake is inadequate

Description	Etiologies	Goals	Interventions
Venous ulcer (venous arterial, mixed; specify if known) location (specify) with the following contributing factors (specify):	Diabetes Neuropathy Change in the foot structure Altered sensation	Healable Non-healable, maintenance (specify: stablilize wound, prevent new wounds, eliminate odour, control pain, infection prevention, advanced dressing, lessen dressing changes as palliative care occurs)	Offloading device (specify) Encourage food, fluids, and supplements as per orders Reduce contributing factors in the environment (specify) Use protective devices for skin (specify) Refer to registered dietitian for nutrition assessment Cleanse and dress Refer to SWAT Team
Vascular Ulcer (venous, arterial, mixed, specify if known), location (specify) with the following contributing factors (specify):	Obesity DVT Fracture Calf muscle atrophy Age Diabetes PAD (for arterial)	Healable Non-healable, maintenance (specify: stablilize wound, prevent new wounds, eliminate odour, control pain, infection prevention, advanced dressing, lessen dressing changes as palliative care occurs)	Elevate leg (venous ulcer) Compression (specify) (tubi-grip, compression stocking, Coban) Encourage food, fluids, and supplements as per orders Refer to registered dietitian for nutrition assessment Cleanse and dress Refer to SWAT Team

Description	Etiologies	Goals	Interventions
Acute Wound (Specify type and location) with the following contributing factors (specify):	Trauma	Healable* Non-healable, Maintenance (specify: Stablilize Wound, Prevent New Wounds, Eliminate Odour, Control Pain, Infection Prevention, Advanced Dressing, Lessen Dressing Changes as Palliative Care Occurs)	Encourage food, fluids, and supplements as per orders Reduce contributing factors in the environment (specify) Use protective devices for skin (specify) Refer to registered dietitian for nutrition assessment Cleanse and dress Refer to SWAT Team
Moisture-associated skin damage, location (specify) with the following contributing factors: (specify)	Incontinence Perspiration	Healable Non-healable, maintenance (specify: stablilize wound, prevent new wounds, eliminate odour, control pain, infection prevention, advanced dressing, lessen dressing changes as palliative care occurs)	Moisture control Barrier cream InterDry

Perley Health's Interprofessional Skin and Wound Care Program Policy

Perley Health	POLICY & PROCEDURE
CATEGORY: RESIDENT/CLIENT CARE	**ISSUE DATE: February 2007**
AUTHORIZED BY: **DIRECTOR OF NURSING**	**REVISION DATE: 12 January 2024**
SUBJECT: Skin and Wound Care Program	

PURPOSE

The purpose of this policy and procedure is to outline and define the Skin and Wound Care Program at Perley Health.

Goals of the Skin and Wound Care Program

- Maintain skin integrity
- Prevent and reduce skin breakdown
- Prevent the occurrence of pressure injuries
- Promote healing of wounds
- Evaluation of the skin and wound program

POLICY

1. Routine skin care to maintain skin integrity and prevent wounds will be provided to all residents.
2. All residents will be rounded on hourly using comfort care rounding to proactively meet the needs of the resident which includes repositioning where appropriate.
3. Strategies to transfer residents safely will be determined by the Physiotherapist and/or the Registered Nurse on admission and as needed.
4. All residents will be assessed for risk of pressure injuries and appropriate interventions and referrals to the interprofessional team.
5. Any resident who has a skin impairment will be:
    a. assessed by a registered staff member using the weekly wound assessment tool
    b. reassessed at least weekly by a registered staff member as clinically indicated; and
        i. Should the skin impairment no longer require weekly monitoring, such as a stable cancer lesion, the Skin and Wound Nurse will provide this recommendation
    c. assessed by the registered dietitian related to nutrition and hydration

6. The Occupational Therapist as well as the Skin and Wound Care Nurse will assess any resident who has a pressure injury.

7. A plan of care will be documented in the Electronic Health Record (EHR) to reflect the resident's goals of care related to skin and wound, interventions, and treatments.
8. An interprofessional team approach will be adopted to achieve a holistic approach to skin and wound care as well as evaluation of the Skin and Wound Care Program (see Appendix A).

APPLICABILITY/SCOPE

The Interprofessional Team

DEFINITIONS

Altered Skin Integrity: Potential or actual disruption of epidermal or dermal tissue.

Interprofessional Team (as identified in the appendix A): A team with different healthcare disciplines working together towards common goals to meet the needs of residents. Team members divide the work based on their scope of practice; they share information to support one another's work and coordinate processes and interventions required for care.

Pressure injury is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure.

Registered Staff: Refers to Registered Nurses and Registered Practical Nurses

PROCEDURE

1. Using an interprofessional team approach, an individualized skin and wound prevention plan will be developed for each resident that is aligned with the resident's goals of care.

2. The plan of care will be developed in accordance with the following principles: person-centred care, an interprofessional team approach, and a balance of benefits, risk, safety, and quality of life. With increasing frailty, a resident's goals of care may shift resulting in varied interventions.

Perley Health	POLICY & PROCEDURE
CATEGORY: RESIDENT/CLIENT CARE	**ISSUE DATE: February 2007**
AUTHORIZED BY: **DIRECTOR OF NURSING**	**REVISION DATE: 12 January 2024**
SUBJECT: Skin and Wound Care Program	

3. All residents will have a Pressure Ulcers Risk Assessment (PURS) completed on admission by the Registered staff to determine the risk of developing a pressure injury.
    - On a quarterly basis, this assessment is completed as part of the RAI process
    - Appropriate interventions will be selected and added to the plan of care to reduce the risk of developing a pressure injury

4. All residents will have a skin assessment by a member of the Registered staff:
    - within 24 hours of the resident's admission
    - upon return of the resident from hospital for a stay greater than 24 hours
    - upon any return of the resident from an absence of greater than 24 hours
    - quarterly

5. A resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds will have:

    - a weekly wound assessment completed by the registered staff using the weekly wound assessment tool under the assessment tab in Point Click Care (PCC);
        - When altered skin integrity is determined to be unchanging such as in a stable cancer lesion, weekly monitoring will be discontinued by the Skin and Wound Nurse
    - a photo of the wound (regardless of type), by the registered staff, saved in Point Click Care (PCC) under the "Misc" tab
    - immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required;
    - assessment by a registered dietitian
    - assessment by an occupational therapist for any pressure injuries
    - assessment by the Skin and Wound Nurse for a wound that is not healing and pressure injuries
    - changes to interventions (by the appropriate team member) and the resident's plan of care as appropriate

Perley Health	POLICY & PROCEDURE
CATEGORY: RESIDENT/CLIENT CARE	**ISSUE DATE: February 2007**
AUTHORIZED BY: **DIRECTOR OF NURSING**	**REVISION DATE: 12 January 2024**
SUBJECT: Skin and Wound Care Program	

REFERENCES

Fixing Long Term Care Act, 2021

Registered Nurses Association of Ontario (RNAO), (2011), Best Practice Guidelines: Risk Assessment and Prevention of Pressure Injuries

APPENDIX

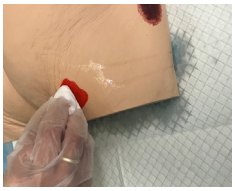
Appendix A - Interprofessional Team Responsibilities

Interprofessional Team Responsibilities

Role	Responsibility
The interprofessional team (includes students and volunteers)	Follow interventions as outlined in the care plan
	Observe and report any changes in resident condition or concerns to the registered staff
	Participate in comfort care rounding as aligned with scope of practice
Registered Staff	Complete skin assessments as outlined in the Skin and Wound Care Program Policy and Procedure
	Implement an individualized plan of care
	Complete weekly wound assessments including a photo of the wound
	Refer to/consult with members of the care team where appropriate (OT,RD, MD)
	Consult SWAT nurse
	Updates and communicates with the resident/Substitute Decision Maker (SDM)
	Participates in skin and wound education
	Enter into the Treatment Administration Record (TAR) the current treatment plan
Personal Support Worker (PSW)	Observe and report any changes in resident condition, specifically skin concerns to the registered staff
	Follow the care plan
	Report to the registered staff when dressings are not intact
	Ensure that comfort care rounding is completed hourly
RAI Registered Practical Nurse (RPN)	Complete RAI MDS assessments at admission, quarterly and with significant changes
Occupational Therapy (OT)	Assess the resident and provide input into the plan of care related to pressure injuries and offloading pressure
Occupational Therapy Assistant (OTA)	Monitors and evaluates as per scope, and supports and corrects proper fit of devices as per scope
Physiotherapy (PT)	Assess the resident and provide input into the plan of care regarding transfers and positioning
Registered Dietitian (RD)	Assess the resident and provide input into the plan of care related to nutrition and hydration
Skin and Wound Assessment Team Nurse (SWAT)	Works with the unit Registered Staff to provide guidance in the plan of care for the resident, may provide suggestions on treatment
Recreation Programmers	Monitor for proper positioning of residents during activities, observes for skin tears and reports all concerns to the Registered Staff
Physician (MD)	Participates in the interprofessional plan of care, assesses complex wounds or makes referral as appropriate

Wound Hygiene Protocol

Goal: The goal of this wound hygiene protocol is to promote wound healing by disrupting and removing biofilm that has accumulated on chronic wounds.

Step	Photo	Action	Rational
1		• Cleanse the wound bed and periwound (10 to 20 cm around the wound) with an antimicrobial wound cleanser. • Use a sufficient amount to remove loose debris.	• This is the first step to wound bed preparation. • This disturbs the biofilm. • Cleansing the periwound will decrease the risk of contamination.
2		• With a sterile 4×4 gauze, rub the wound gently to remove devitalized tissue and debris.	• Gently rubbing the wound bed will prepare the wound bed for healing by removing devitalized tissue and debris. This will also disturb biofilm.
3		• Re-cleanse the wound bed with the antimicrobial wound cleanser.	• By re-cleansing the wound bed, broken-down biofilm will further be removed.
4		• With a sterile 4×4, remove any dry, scaly or necrotic tissue by rubbing the wound edges gently.	• Removes debris present on the wound edges. • Encourages epithelization, promoting wound healing.
5		• Dress the wound. Choose an antimicrobial dressing if you have a positive NERDS* or STONEES**.	• This promotes moist wound healing. • An antimicrobial dressing will slow down the build up of biofilm.

***NERDS**

(Any three or more NERDS indicates a superficial bacterial burden; consider topical antimicrobial product for a two-week challenge.)

- **N**on-healing: Wound that is not 20-40% smaller in four weeks
- **E**xudative wound: Increase in wound exudate or more than 50% of dressing is stained with exudate.
- **R**ed and bleeding: wound bed tissue is bright red or tissue bleeds easy with gently manipulation.
- **D**ebris: presence of discolored granulation tissue, slough or necrotic tissue.
- **S**mell: unpleasant or sweet sickening odour.

****STONEES**

(Any three or more of STONEES indicates a bacterial infection in the deep compartment, consider systemic antibiotics +/- topical antimicrobial product)

- **S**ize: An increased wound size may be due to deeper tissue damage caused by bacteria, the cause of the wound not being treated, or a local or systemic cause.
- **T**emperature: Infection should be suspected if there is a greater than three degree temperature difference between the two mirror image sites e.g. right and left heel.
- **O**s: Osteomyelitis should be suspected if you can probe to exposed bone or bone is visible.
- **N**ew areas of breakdown.
- **E**rythema /edema.
- **E**xudate: Increase in wound exudate.
- **S**mell: Unpleasant or sweet, sickening odour.

Reference: Murphy, C., Atkin, L., Swanson, T., Tachi, M., Tan, Y.K., Vega de Caniga, M., Weir, D., and Welcott. R., (2020) Defying hard-to-heal- wounds with an early antibiofilm intervention strategy: wound hygiene. Retrieved July 2020 from magolinelibrary.com

Woo, K. Y., & Sibbald, R. G. (2009). A cross-sectional validation study of using NERDS and STONEES to assess bacterial burden. Ostomy Wound Management, 55(8), 40–48. https://pubmed.ncbi.nlm.nih.gov/19717855

Wound Treatment Scheduling Case Study and Answer Key

Case Study - Wound Treatment Scheduling

A resident is due for a scheduled wound care treatment on Unit A. The scheduled reminder is posted in the nursing communication book, as per common practice on Unit A. Today, a casual nurse from Unit B is covering. Unit B doesn't typically use a nursing communication book; they always schedule treatments in the Treatment Administration Record. As a result, the casual nurse does not immediately see that a treatment is due and plans her day without that task. When the resident asks about the treatment near the end of the shift, the nurse scrambles to complete it, feeling frustrated. When the treatment instructions are finally found, it reads, "Change dressing to wound until healed." The nurse spends 20 minutes seeking treatment instructions in the resident's chart.

1. What are the problems with this scenario?

2. What are the are the risks of these challenges?

3. Which systemic scheduling strategies could help improve care?

Answer Key:

1. The nurse almost missed a resident treatment due to inconsistent communication methods, the resident is not experiencing excellent care due to having to ask for planned treatments, the nurse is stressed due to this last-minute care need, and the nurse loses time having to figure out treatment details due to lack of information.
2. There is a risk of physical harm to the resident from delayed wound healing due to missed or incorrect treatment, the risk of reputation loss for the organization due to perceived poor resident-centered care, the risk of staff stress and burnout due to frustration and confusion, the risk of malpractice for the nurse due to almost missing a treatment, and the risk of wasted resources due to nurse's lost time trying to figure out action plan.
3. Having a consistent treatment scheduling method across the entire home and having a standard approach to writing treatment orders to ensure they contain all the required information.

Facilitator's Guide to the "Skin and Wound Care Carnival" Training

Skin and Wound Carnival

The Skin and Wound Carnival is a 10 to 15-minute training designed to be delivered at the point of care. It aims to be both educational and engaging for learners.

Purpose: To train staff at the point of care on four common knowledge and skill gaps when providing quality skin and wound care in the following key areas: applying Tubigrip, wound cleansing technique, distinguishing between inflammation and infection in a wound, and recognizing the difference between different skin creams.

Goal: The learner will gain knowledge and skill in at least one of the above-mentioned skin and wound care learning needs.

General Set-up

Supplies:

- Cart with a flat working surface on the top and storage underneath.
- Container filled with little paper pieces, each with one of the four different carnival games written on them:
  - Tubigrip Challenge
  - Wound Hygiene Challenge
  - Inflammation versus Infection Challenge
  - Moisturizer, Barrier, or Dressing Cream challenge
- You can substitute this with any other method of randomly selecting a challenge from four options
- One or two training facilitators. (It is recommended that facilitators have training or clinical familiarity with the topics covered in the Skin and Wound Care Carnival training.)

Instructions:

1. Roll the cart around on the units and approach staff to participate in a fun and inviting way. Staff can participate in groups if they want to.
2. Ask a participant to pick a piece of paper from the box. They will play the game that correlates with the challenge title that they chose.
3. To maximize participation:
   i. Bring participation incentives and giveaways (i.e. wrapped candy, pens etc.)
   ii. Choose training times that are preferred by the unit staff.
   iii. Do not interrupt staff providing direct resident care.

Carnival Game 1: Tubigrip Challenge

Purpose: To practice measuring and applying Tubigrip.

Goal: The learner will discover how to choose the correct Tubigrip length from different options and demonstrate the proper application technique on a leg.

Target Audience: Personal support workers (PSW), registered staff

> **Tip**
>
> **What is Tubigrip?**
>
> Tubigrip is a tubular bandage that provides support and compression to legs for a variety of conditions.

Supplies:

- A leg (a task trainer, a fake leg, or a volunteer's leg.)
- Four or five pieces of Tubigrip cut to different lengths.
  - One should be the correct length.
  - The others should be the incorrect lengths, either too long or too short.
- Optional: Printed Tubigrip application instructions, which can typically be accessed through Tubigrip retailers.

Set up:

1. Show the leg and the Tubigrip options (mixed up).

Instructions:

1. Direct the learner to choose the Tubigrip length option that they think would be the most appropriate length for the leg.
2. Direct the learner to apply their chosen Tubigrip to the leg.
3. Once the learner has completed the task, provide feedback on their choice and technique, including tips and strategies on how to properly measure and apply Tubigrip on a leg.

Carnival Game 2: Wound Hygiene Challenge

Purpose: To practice cleaning a wound.

Goal: The learner will demonstrate proper wound hygiene techniques to remove a wound's biofilm.

Target Audiences: Registered staff

Supplies:

- A wound (a wound task trainer or a photo wrapped in plastic wrap.)
- Vaseline colored with green food coloring (imitation biofilm)
- Cotton tip applicator
- 4×4 sterile gauze
- Antimicrobial wound cleanser
- Normal saline
- Wound hygiene protocol (View Appendix F)

Setup:

1. Use the cotton top applicator to apply a thin layer of the green Vaseline to the wound bed.
2. Display the cleaning supplies beside the wound: (4×4 sterile gauze, antimicrobial wound cleanser, normal saline, etc.) Include a commonly incorrect option, like normal saline.

Instructions:

1. Direct the learner to choose the supplies they would use to cleanse the wound.
2. Direct the learner to complete all steps of wound cleansing.
3. Once the learner has completed the task, provide feedback on their supply choices and wound cleansing technique, including tips and strategies on how to properly complete the task.

Carnival Game 3: Inflammation versus Infection Challenge

Purpose: To practice applying the "NERDS" and "STONEES" framework to wound assessments.

Goal: The learner will be able to distinguish between a wound being inflamed or infected.

Target Audience: Registered staff

Supplies:

- Four or five pictures of inflamed and infected wounds. (Tip: Pull pictures from the internet or use de-identified pictures of wounds from within the organization with the residents' documented permission.)
- Wound hygiene protocol with "NERDS" and "STONEES" tool (View Appendix F.)

Setup:

1. Lay out the pictures of the infected and inflamed wounds on the cart surface.

Instructions:

1. Give the learner the "NERDS" and "STONEES" tool.
2. Direct the learner to categorize each wound picture as either inflammation or infection
3. Once the learner has completed the task, provide feedback on their categorical decisions, including an overview of how to properly apply the "NERDS" and "STONEES" framework.

Tip

What are "NERDS" and "STONEES"?

"NERDS" and "STONEES" are mnemonics that help healthcare providers determine the level of bacterial burden in a wound, guiding treatment recommendations.

"NERDS" is a mnemonic for identifying inflamed wounds with superficial bacterial burden.

"STONEES" is a mnemonic for identifying wounds with deep tissue infections.

Carnival Game 4: Moisturizer, Barrier, or Dressing Cream Challenge

Purpose: To distinguish between three common, but often misused, skin creams: moisturizers, barrier, and dressing creams.

Goal: The learner will be able to correctly choose and apply the right type of skin cream for the presented skin conditions.

Target Audience: Personal support workers (PSW), registered staff

Supplies:

- Three pictures of buttocks with different skin conditions: one with moisture associated skin damage, one with xerosis, and one with a stage 3 pressure injury. (Tip: Pull pictures from the internet or use de-identified pictures of buttocks from within the organization with the residents' documented permission.)
- Barrier cream.
- Dressing cream.
- Moisturizing cream.

Setup:

1. Display the three pictures on the cart surface beside the three cream options (mixed up).

Instruction:

1. Direct the learner to inspect and assess the three buttocks pictures.
2. Direct the learner to match the appropriate cream with the skin condition depicted in the pictures.
3. Once the learner has completed the task, provide feedback on their choices, including clinical rationale for the correct choices.
4. Tip: Feedback and explanations will vary between personal support workers and registered staff, due to the differences in clinical scopes of practice. For example, it is not recommended that PSWs apply dressing creams in long-term care.

Notes:

Nothing short of excellent.

Established in 2019, the Perley Health Centre of Excellence in Frailty-Informed Care™ aims to set a new benchmark for Senior and Veterans care, facilitating applied research that fuels innovation in education, best practices, and knowledge translation. Our goal is to ensure Seniors and Veterans living with frailty receive the highest level of care, both within our walls and beyond.

The CoE conducts practical, applied research, and uses health system data to better understand the needs of older adults and Veterans living with frailty. We focus on solutions that address each person's individual needs, and we aim to find innovative solutions to care.

We welcome collaboration with a wide range of stakeholders who want to work with us to serve older adults and Veterans to optimize care and quality of life by addressing the physical, social, psychological and spiritual domains of health.

If you are a researcher, older adult, Veteran, caregiver, clinician, or health care provider, please reach out to discuss how we can transform research into practical solutions, programs, and care services to benefit older adults and Veterans living in at home, in long-term care, or elsewhere.

The Center of Excellence is supported through the generosity of donors who all share a commitment to transforming care for Seniors and Veterans.

Was this field guide useful?

Tell us what you think by scanning the QR Code.

Complete the survey before May 1, 2026 for a chance to win one of four $25 gift cards!

You can always email us at centreofexcellence@perleyhealth.ca

Please visit PerleyHealth.ca/centreofexcellence to learn more or email: centreofexcellence@perleyhealth.ca.

We look forward to working together to transform care for Seniors and Veterans.

Perley Health
Centre of Excellence in Frailty-Informed Care™