



## PLAYING THE BEST OFFENSE IN WOUND CARE PRODUCT SELECTION



**Patricia Larsen, PT, MSPT, CWS, OMS, WCC** is a certified wound and ostomy specialist and physical therapist, focused on strategies for effective wound treatment, emphasizing wound hygiene and optimal product selection for acute & hard-to-heal chronic wounds.



**WATCH NOW:** Playing the Best Offense in Wound Care Product Selection

### Webinar Key Learning Objectives:

- 01** Review the healing process for acute wounds and evaluate the complex challenges faced with chronic hard-to-heal wounds.
- 02** Discuss and contrast the treatment options available for wound cleansing and debridement.
- 03** Overview recommended methods for disrupting biofilm and treating infection during wound healing.
- 04** Summarize the supporting guidelines and clinical evidence to achieve optimal outcomes.

## The Offense: 3-Part Wound Hygiene

**Step 01**

### THERAPEUTIC CLEANSING

- » Clean wound and 10–20 cm around it
- » Use sufficient force to disrupt adherent biofilm (not drip-and-pat)
- » Prefer antimicrobial / antiseptic / surfactant cleansers
- » Normal saline alone = no longer enough for chronic/hard-to-heal

**Step 02**

### DEBRIDEMENT (SERIAL)

- » Goal: remove devitalized tissue + biofilm
- » Aim for pinpoint bleeding when appropriate → platelet release → kickstarts healing
- » Use what the setting allows: mechanical (monofilament pads), autolytic, enzymatic, sharp, ultrasound, hydro-surgical
- » Do something at every dressing change

**Step 03**

### RE-FASHION THE EDGE

- » Roll, callus, hyperkeratosis at the edge = healing roadblock
- » Refresh edges regularly → that's where new epithelial cells come from
- » Clean peri-wound just like wound

## Step 1 Deep Dive: Cleansing That Actually Disrupts Biofilm

Do this	Not Enough
Use cleanser with surfactant (lifts & binds debris)	Dribble saline on gauze and pat
Use cleanser with broad-spectrum antimicrobial (bacteria and fungus)	Cleaning only the wound and not the peri-wound
Clean everything under the future dressing/wrap	
Choose method: irrigate / spray with PSI / pressurized system depending on wound	Using cytotoxic agents too long on a wound we actually want to heal

## Talking About Cleansers Without Getting Brand-Specific



### (Preferred / Guideline-aligned)

- » Antimicrobial cleansers (hypochlorite/hypochlorous blends, some with surfactant)
- » Surfactant-based wound cleansers
- » Lower-pH, non-cytotoxic, broad-spectrum options
- » Often compatible with most dressings/enzymatics (check label)



### (Situational / Short-term)

#### Dakin's / betadine / acetic acid

- 👍 Good for odor, high bio-burden, non-healable, palliative
- 👎 Cytotoxic → limit to ~7 days if you actually want to heal

#### CHG/peri-wound washes

- 👍 Good peri-wound hygiene
- ☑ Check compatibility (some dressings get inactivated)



### (not for chronic/hard-to-heal as routine)

- » "Just saline" for a wound that has been open >72 hours
- » Repeated hydrogen peroxide on granulating tissue

### What to Look for on the Label

- ☑ Says antimicrobial (not just "preservative")
- ☑ Identifies what it's active against (bacteria? fungus? both?)
- ☑ States non-cytotoxic / isotonic
- ☑ Compatible with your other products (CHG? Santyl?)
- ☑ Has instructions for soak/contact time
- ☑ Has FDA clearance language you can pull if Materials Mgmt asks

Why antimicrobial? Biofilm can form within 72 hours of skin break → chronic wounds are often polymicrobial (bacteria + fungus).



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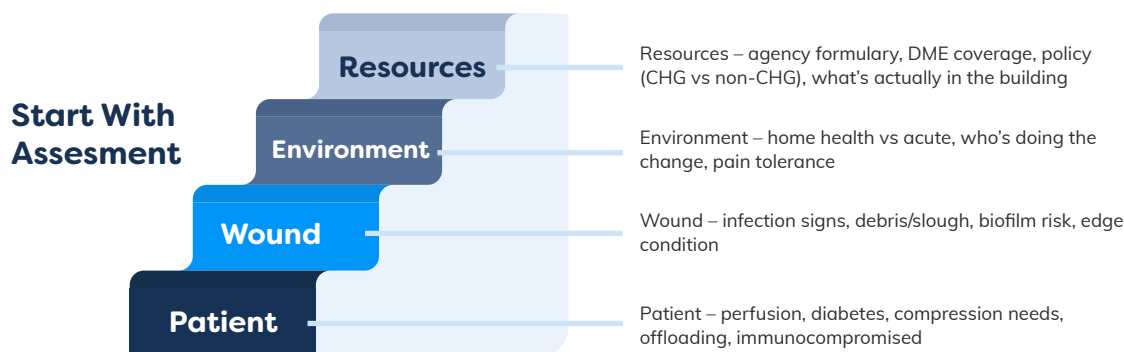


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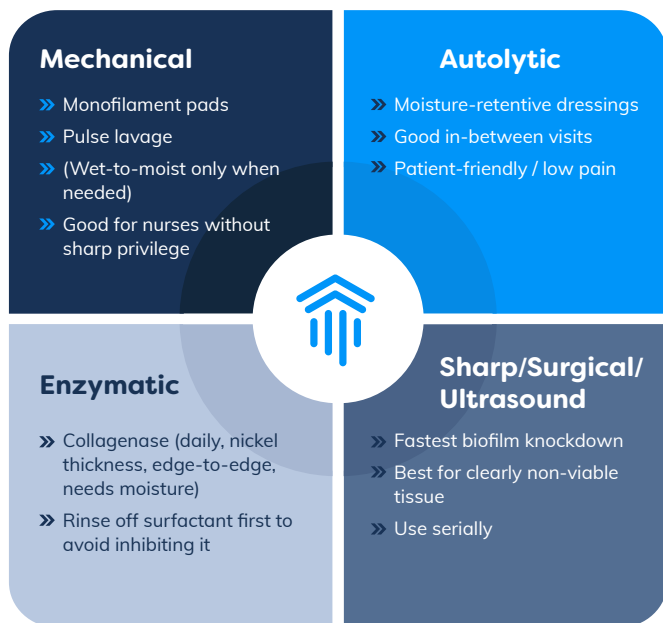
### Make Every Dressing Change a Reassessment



**It doesn't matter what we put in the wound if we don't fix what's under it.**



### Debridement Options at a Glance



### Moisture Balance Still Matters

**If it's dry** → Add moisture (supports autolysis)

**If it's wet** → Pull it away (protect peri-wound, prevent maceration)

**Re-check every visit – wounds don't stay in one moisture state**

**Do small debridement often > big debridement rarely.**