

National best practice and evidence based guidelines for wound management



QUICK REFERENCE GUIDE

General Principles of Wound Management

- Comprehensive assessment of the patient and the wound should be completed by a person trained in such assessment.
- The aetiology of the wound should be determined with referral to appropriate members of the multi-disciplinary team when further investigation or intervention is required.
- All aspects of care from initial presentation through to treatment and evaluation should be documented.
- Following assessment, treatment goals should be agreed with the patient and a time frame for their achievement set.
- Underlying factors which could influence the potential for wound healing should be addressed.
- Each clinician involved in the provision of care must work within their Scope of Practice and is accountable for their practice.
- When cleansing the wound, potable tap water is suited for chronic wounds and in adults with lacerations.
- An aseptic wound cleansing technique is required when the individual is immuno-compromised and/or the wound enters a sterile body cavity.
- All wound dressings should be used in accordance with manufacturer's instructions and the integrity of such products must be ensured through proper storage and use.
- Surgical wound dressings should be left dry and untouched for a minimum of 48 hours post-operatively to allow for re-establishment of the natural bacteria-proof barrier, unless otherwise clinically indicated.

Leg Ulceration

- Patients presenting with lower limb ulceration should have assessment and investigation undertaken by health care professionals trained in leg ulcer management.
- All such patients should be screened for evidence of arterial disease by measurement of ABPI by a person trained in such measurement.
- ABPI should be conducted when: an ulcer is deteriorating, is not fully healed by 12 weeks, is recurrent, prior to commencing compression therapy, when there is sudden increase in wound size, sudden increase in wound pain, change in colour and/or temperature of the foot or as part of on-going assessment.
- Graduated compression therapy with adequate padding, capable of sustaining compression for at least one week should be the first line of treatment for uncomplicated venous leg ulcers. This should be applied by a person trained in its application.
- Removal of devitalised tissue will promote wound healing. However, in arterial ulcers with dry gangrene or eschar, debridement should not be performed until arterial flow has been established.
- Routine use of antibiotics is unnecessary unless there are signs of infection.

Diabetic Foot

- All persons with diabetes should be examined at least once a year for potential foot problems. Patients with demonstrated risk factors for foot ulceration should be examined more often – every 1-6 months.
- In a high risk patient, callus and nail and skin pathology should be treated regularly, preferably by a trained foot care specialist.
- Infection in a diabetic foot presents a direct threat to the affected limb and should be treated promptly and actively.
- Patients with an ulcer deeper than subcutaneous tissues should be treated intensively and depending on local resources and infrastructure, hospitalisation must be considered.
- Neuropathic ulcers should be debrided as soon as possible by a person trained in debridement. This debridement should not be performed in ischaemic or neuro-ischaemic ulcers without signs of infection.
- If one or more pedal pulses are absent or if an ulcer does not improve despite optimal treatment, more extensive vascular evaluation should be performed. As a first step, the ABPI can be measured. ABPI may be falsely elevated due to calcification of the arteries. Preferably other tests such as measurement of the toes pressure or transcutaneous pressure of oxygen should be used.
- Ill fitting shoes are a frequent cause of ulceration and therefore shoes should be examined meticulously in all patients.



Pressure Ulcers

- Each health care setting should have a pressure ulcer prevention policy in place. This should include recommendations for the structured approach to risk assessment relevant to the health care setting, the timing of risk assessment and reassessment, clear recommendations for documentation of risk assessment and communication to the wider healthcare team.
- Conduct a structured risk assessment on admission, and repeat as regularly and as frequently as required by patient acuity. Reassessment should also be undertaken if there is any change in patient condition.
- Develop and implement a prevention plan when individuals have been identified as being at risk of pressure ulcer development.
- Ensure that a complete skin assessment is included in the risk assessment screening policy in place in all health care settings.
- Inspect skin regularly for signs of redness in individuals identified as being at risk of pressure ulceration. The frequency of inspection may need to be increased in response to any deterioration in overall condition.
- Skin inspection should include assessment for localized heat, oedema or induration (hardness), especially in individuals with darkly pigmented skin.
- Observe the skin for pressure damage due to medical devices.
- Do not use massage for pressure ulcer prevention
- Do not vigorously rub skin at risk for pressure ulceration.

- Screen and assess nutritional status for every individual at risk of pressure ulcers in each health care setting.
- Repositioning should be undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body.
- Repositioning should be undertaken using the 30 degree semi Fowler position or the prone position and the 30 degree-tilted side lying position (alternately right side, back, left side) if the individual can tolerate this position and the medical condition allows. Avoid postures that increase pressure, such as the Fowler's over 30 degree or the 90 degree side lying position, or the semi-recumbent position.
- Limit the time an individual spends seated in a chair without pressure relief.
- Education in the role of repositioning in pressure ulcer prevention should be offered to all persons involved in the care of individuals at risk of pressure ulcer development, including the individual and significant others (where possible).
- Do not use either the perceived level of risk or category of pressure ulcer only to select a support surface.
- Choose a support surface compatible with the care setting.
- Inspect the skin of the heels regularly.
- Heel protection devices should elevate the heel completely (off load) in such a way as to distribute the weight of the leg along the calf without putting pressure on the Achilles tendon. The knee should be in slight flexion.