Wound Care

"Can't you ever forget you once worked in a gift shop?"

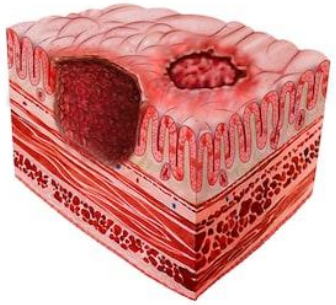
Types of Wound

Acute

- Short healing times
- Pass through stages of healing in timely manner
- Healing often by primary intention
- Include:
  - Trauma
  - Surgery/surgical incisions
  - Abrasions
  - Skin tears
  - Penetrating injuries
  - Burns

Chronic

- Fail to proceed through an orderly and timely process
- Present for more than 4 weeks
- Healing by secondary intention
- Characterised by delayed healing & recurrent infections often become ‘stuck’ in early stage of healing
- Contain a hostile environment not conducive to healing
- Include:
  - Leg Ulcers
  - Pressure Ulcers
  - Diabetic Foot Ulcers



Factors Affecting Wound Healing

Wound Assessment

Insert number to help wound identification esp. if multiple wounds. Ensure this number corresponds with Treatment Chart

Onset relates to when the wound first developed or the duration the wound has been present

Be accurate & consistent when identifying the location of the wound

Wound Number: *1*	**Onset:** *1 week ago (approx. date)*	**Location:** *Outside left leg above the ankle*
Local factors that may delay healing: *Underlying systemic inflammation (RA), potential poor circulation (thin skin, RA), negative effect of steroids, negative effect of previous scar tissue, effect of pain & poor sleep*		

Identify the patient's factors that delay healing & address where possible

RA = Rheumatoid Arthritis

Wound Assessment –

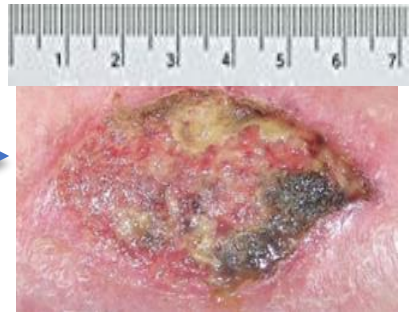
Completing the wound assessment chart

Don’t forget to include type of wound in the notes as this is not included on the chart

Wound dimensions (express in max. cm)	Date	01/04/2020			
	Width				
	Length				
	Depth				
	Undermining (parallel to skin)				
	Photo	Y / N	Y / N	Y / N	Y / N

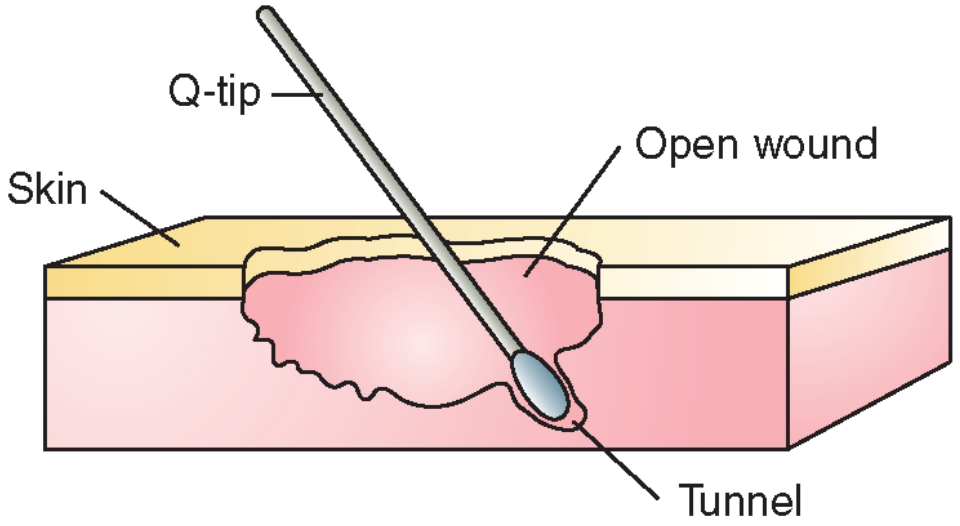
Length = head to toe direction
Width = hip to hip direction
Depth = measure deepest part of visible wound bed
Tunneling = course or pathway that can extend in any direction from the wound, results in dead space
Undermining = tissue destruction underlying intact skin along wound margins

Include date & ruler on photo. Take detailed image of wound & one of wound in context of anatomical area. Take further photos at reassessments to compare progress

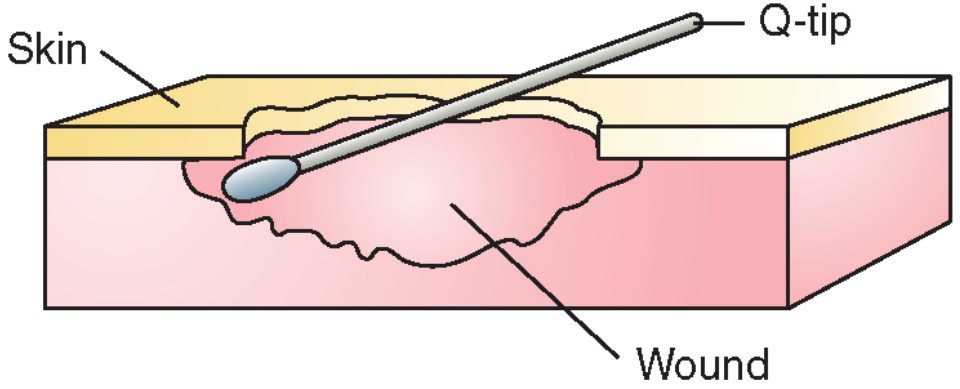


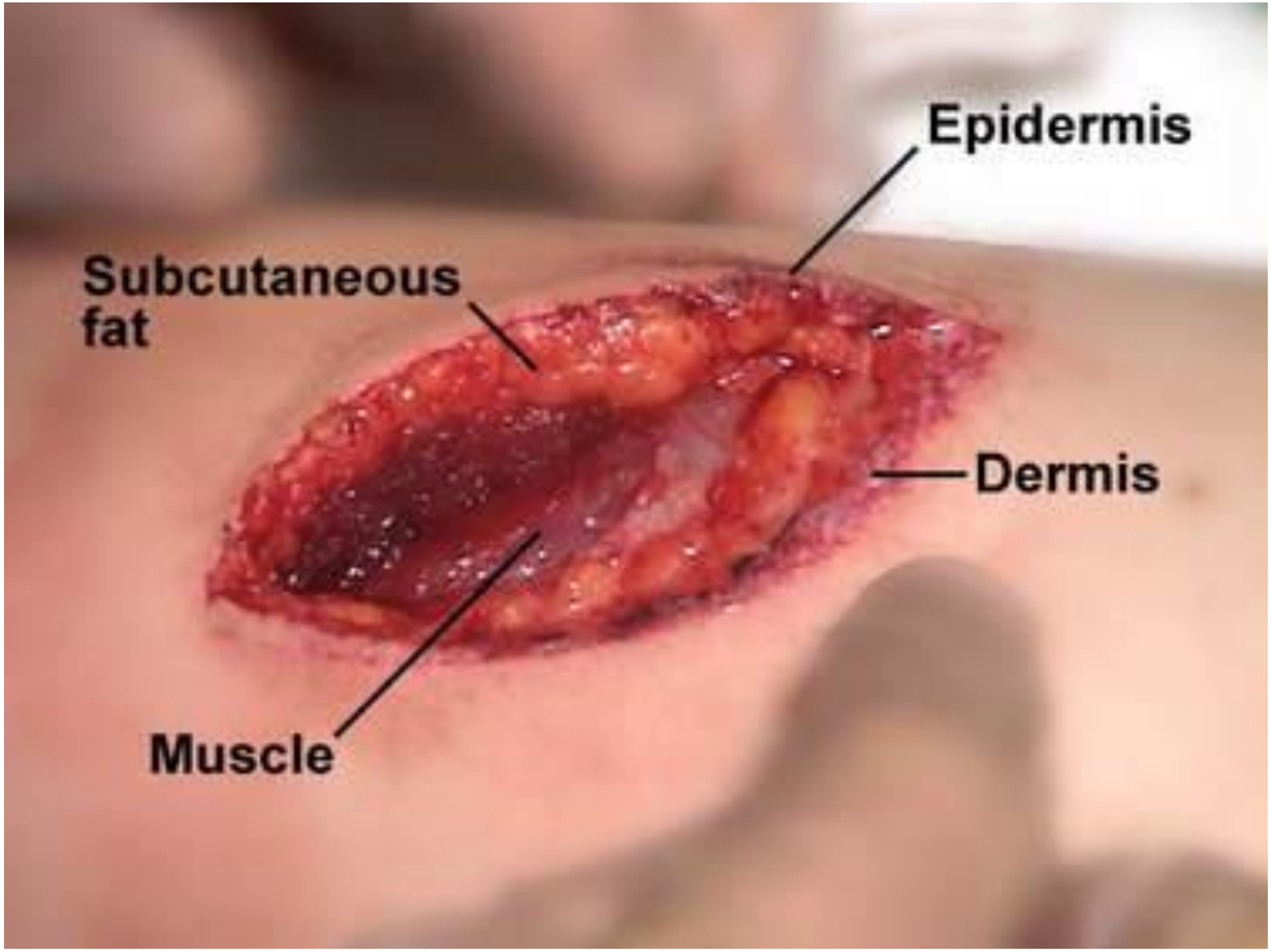
Look for a reduction in size at subsequent assessments that might indicate progress with healing.

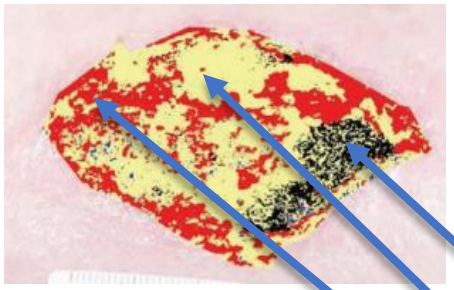
A. Tunneling



B. Undermining




Epidermis
Subcutaneous fat
Dermis
Muscle



Category of wound (express as a %)					
	Necrotic	25 %			
	Sloughy	40 %			
	Granulating	35 %			
	Epithelialising	Y / N	Y / N	Y / N	Y / N
	Infected	Y / N	Y / N	Y / N	Y / N
	Local/systemic	Local			
	Swab taken	Y / N	Y / N	Y / N	Y / N
	Systemic temperature	37.3^{0}C			
	Pressure ulcer grade EPUAP	Category			

Autolytic Debridement

The way in which the body gets rid of dead tissue

Look for signs of Infection

- Is it:
  - superficial or localized to the wound & initial surrounding area
  - Is it evident it is spreading & the patient has systemic signs (pyrexial, malaise, nausea, chills, aches cellulitis, lymphangitis etc)
- Ensure swab is taken for C&S.
- Ensure you take the patient's temperature (signs/at assessments)
- Older patients with necrotic & sloughy wounds are more at risk of sepsis

Local Signs of Infection

- New, increased or altered pain
- Delayed (or stalled) healing or extension in size
- Periwound oedema
- Bleeding or friable granulation tissue
- Distinctive malodour or change in odour
- Wound bed discolouration
- New areas of slough/necrosis
- Increased, altered or purulent exudate
- Induration
- Pocketing or bridging

Several concurrent signs could indicate the presence of infection

How far does the erythema spread from the wound edge? Significant for ascertaining infection or spreading infection

Is it blanching or non-blanching? Significant for indicating extent of pressure damage

Condition of surrounding skin (Tick as appropriate)					
	Macerated				
	Red				
	Callous				
	Oedema				
	Red Erythema				
	Purple Erythema				
	Maximum distance from wound site (cms)				
	Eczema				
	Fragile				
	Dry/Scaling				
	Healthy/Intact				

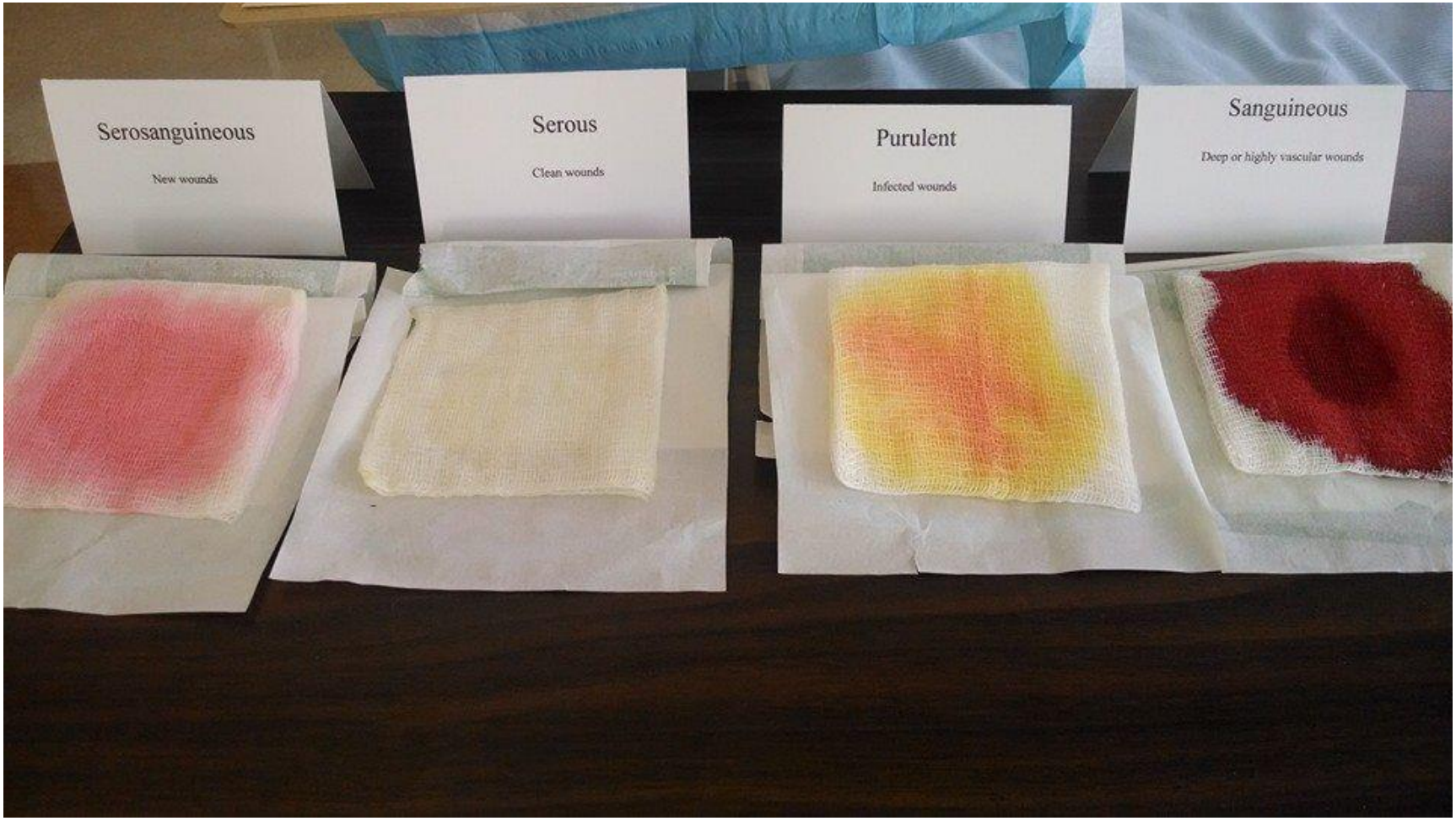
Colour & viscosity can indicate the current stage of wound healing.
↑exudate level, changes in colour &
↑viscosity can indicate onset of infection

Exudate	Slight/Moderate/Heavy	S / M / H	S / M / H	S / M / H	S / M / H
	Colour	Yellow			
	Consistency	Viscous			
Odour	Strong/Moderate/ Slight/No odour	Str / Mod Sli / No	Str / Mod Sli / No	Str / Mod Sli / No	Str / Mod Sli / No

SLIGHT - Odour on entering room with dressing intact

MODERATE Odour on entering room with the dressing removed 2-3m away

STRONG - Close proximity to the patient with dressing removed


Serosanguineous
New wounds
Serous
Clean wounds
Purulent
Infected wounds
Sanguineous
Deep or highly vascular wounds

Pain (Scale 0-10: 0 = no pain; 10 = severe pain)	Yes/No	Y / N	Y / N	Y / N	Y / N
	Intermittent	0			
	Continuous	4			
	At dressing change	6			
	Pre-analgesia	5			
	Post-analgesia	3			

Changes to the level & frequency of pain can indicate infection or the onset of underlying disease/pathology.
Pain affects concordance

Date for re-evaluation	01/05/2020			
Assessor's name	Nick Crosis			
Signature	Nick Crosis			

Ensure the date for re-evaluation is completed.

Add the date to Team Planner or a Team Diary so this is not missed.

In he Community, the wound must be reassessed as a minimum every 4 weeks.

In the Community surgical wounds are assessed weekly

In In-Patients all wounds are reassessed weekly as a minimum

Reassessment: Evaluating the progress of Wound Healing:

- An improvement should be noted within 2 – 4 weeks of commencing treatment
- Signs will include:
  - a reduction in devitalised tissue
    - (slough & necrosis)
  - evidence of granulation
  - reduction in exudate & malodour
  - epithelialisation at wound edges / islands over wound bed
  - percentage reduction in wound surface area

Wound care treatment chart

Wound number: 1

Wound care objectives:

1. Debridement
2. Reduce bacterial load
3. Management of malodour
4. Hydrate
5. Promote granulation
6. Controlling excess exudate
7. Manage pain
8. Manage moisture level
9. Address the cause
10. Prevent deterioration
11. Reverse venous hypertension
12. Address personal hygiene

Date	29.2.16	
Wound care objective	5 & 6	
Cleansing required Solution Method	(Y) N Normal Saline Irrigation.	Y / N
Emollient/skin preparation Product Method	(Y) N Cavilon No Sting Barrier Film Apply to surrounding skin	Y / N
Primary dressing Product Size Quantity Method	(Y) N Aquacel Extra 10X10 1 Apply to wound bed	Y / N
Secondary dressing Product Size Quantity Method	(Y) N Allevyn Gentle Border 10X10 1 Apply over Aquacel	Y / N
Retention dressing/bandage Type Size Method	Y / (N)	Y / N
Pain management during dressing changes Product Frequency Special Instructions	(Y) N Paracetamol 4 x day (every 6 hours) Take 1 hour prior to dressing.	Y / N
Frequency of changes	Every 2-3 days / prn	
Name and sign	Mia Carr	
Date for re-evaluation	2/52 ~ 14.3.16	
Re-evaluated-no change Name/date/sign	14.3.16	
Date for re-evaluation	2/52 ~ 28.3.16	
Re-evaluated-no change Name/date/sign		
Date for re-evaluation		

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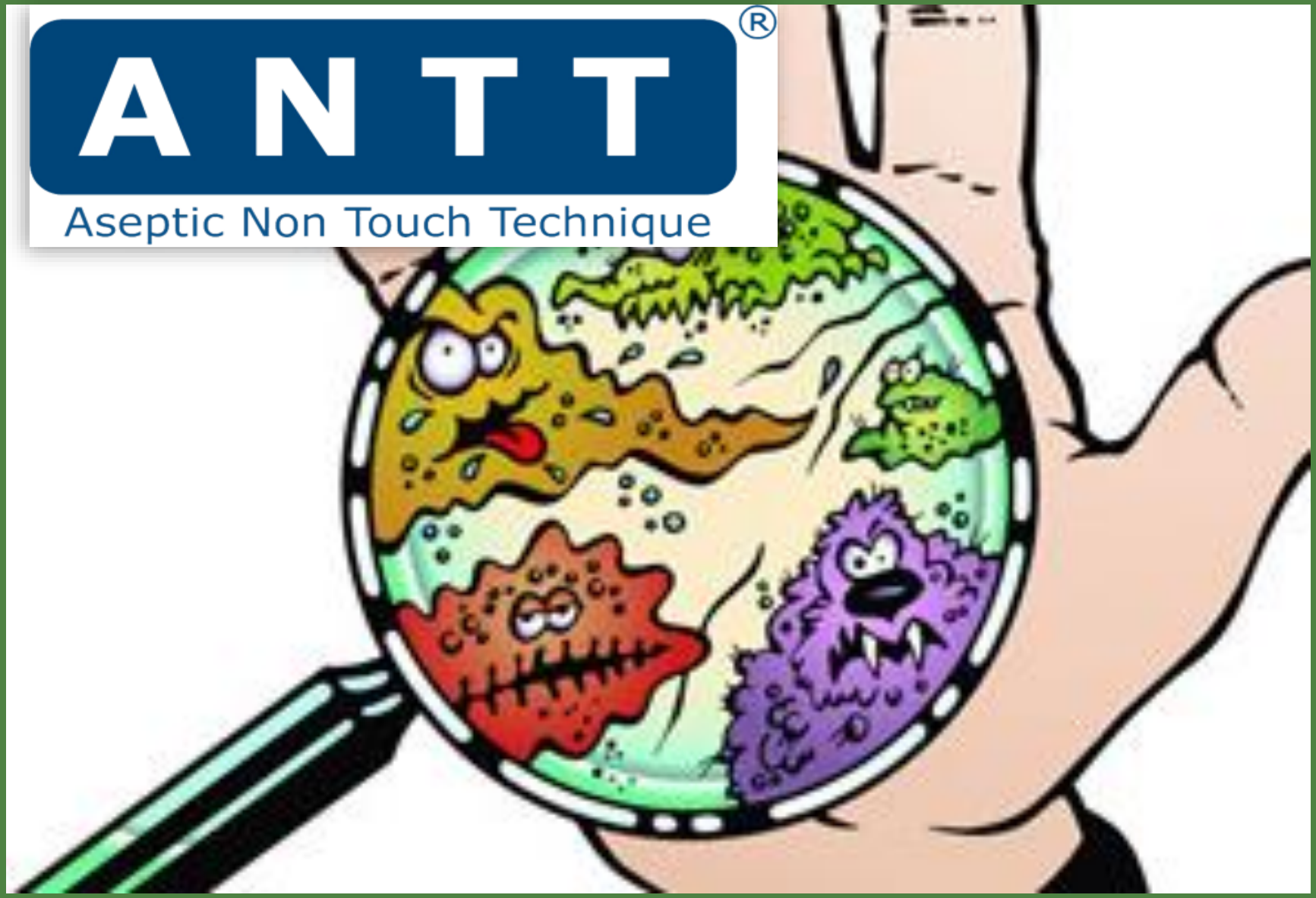
ANTT®

Aseptic Non Touch Technique



ANTT – Risk Assessment

Consult client care plan/record to inform wound care

Turn off fan & close window before procedure

Request pets are removed from room where procedure being undertaken

ANTT – Prepare Patient

Ensure patient comfort – pain relief

Ensure patient comfort - position

Ensure patient comfort – toileting

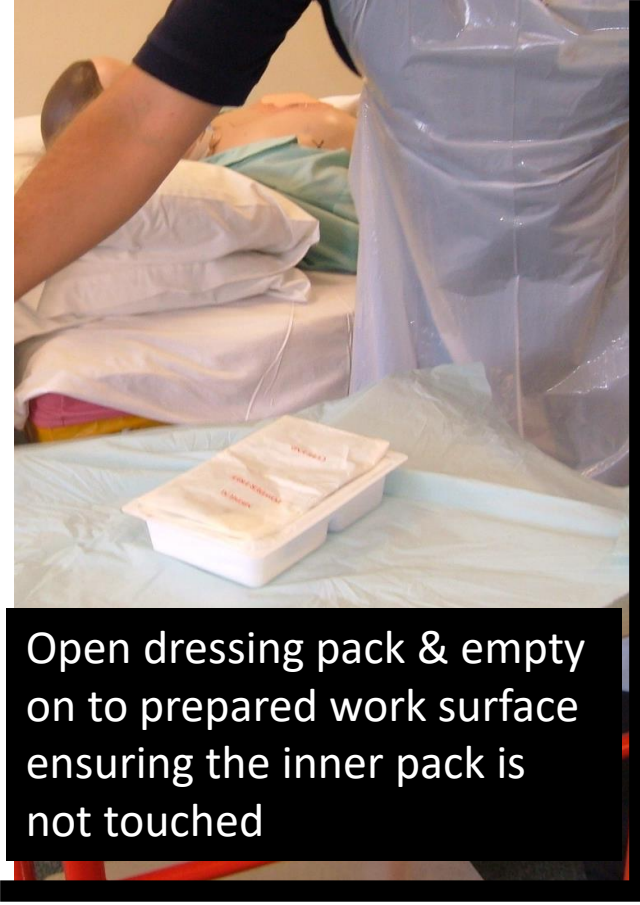
ANTT – Prepare Equipment & Workspace

Hand hygiene -wash hands

Gather necessary equipment

Check dressing pack & sterile items to ensure sterile, no breach & in date

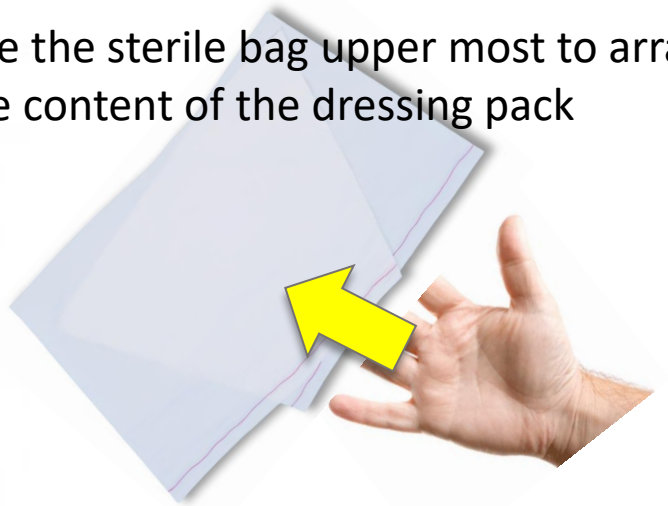
Clean work space



ANTT – Opening up the Dressing Pack

ANTT – Opening up the Dressing Pack

Use the sterile bag upper most to arrange the content of the dressing pack



Put on the enclosed apron

Richardson wound dressing pack contents

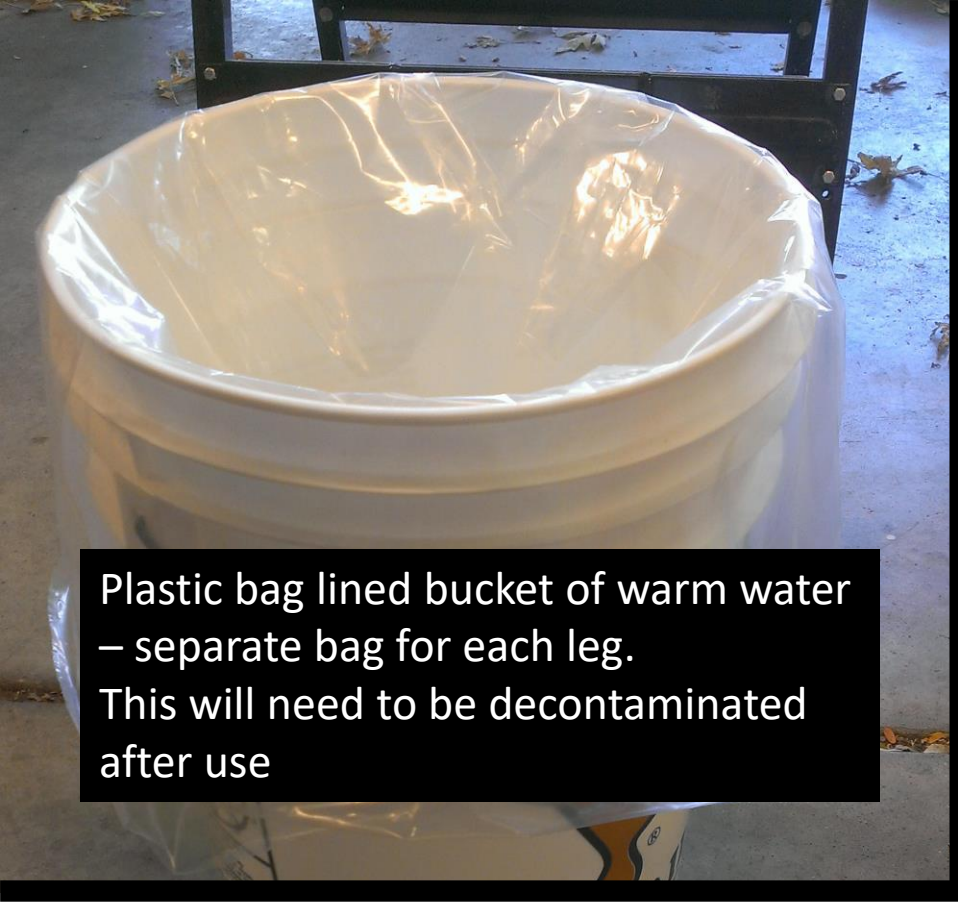
Place a sterile towel / clean field under the anatomical site of the wound

ANTT – Removing the Dressing

Either use the dressing disposal bag & turn inside out afterwards or non-sterile gloves

Dispose of old dressing & non-sterile gloves in the wound dressing disposal bag

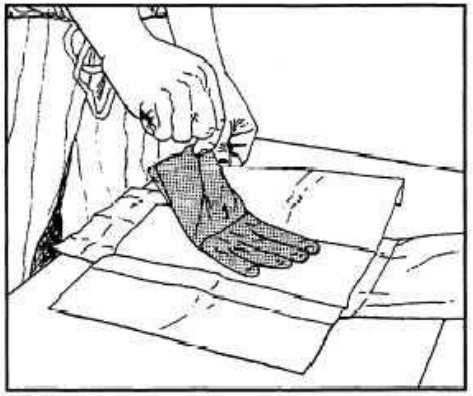
Decontaminate hands

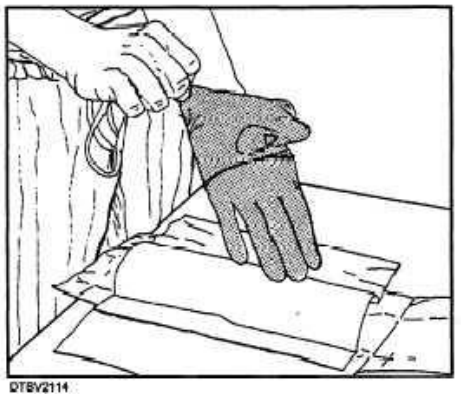


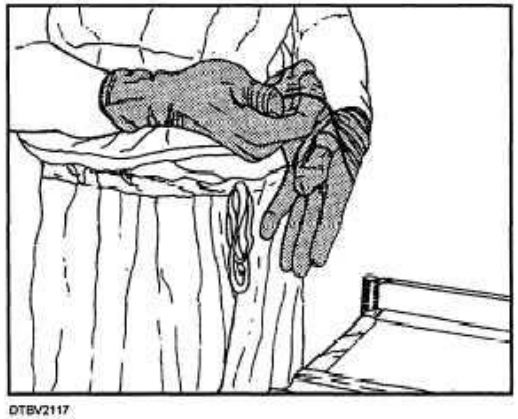
Cleansing Leg Ulcers

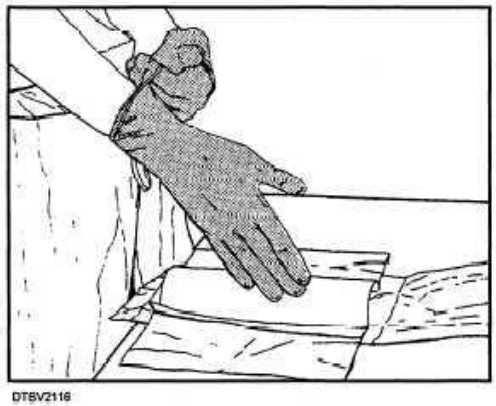
ANTT – Applying Sterile Gloves

Hold the gloves by the folded cuff



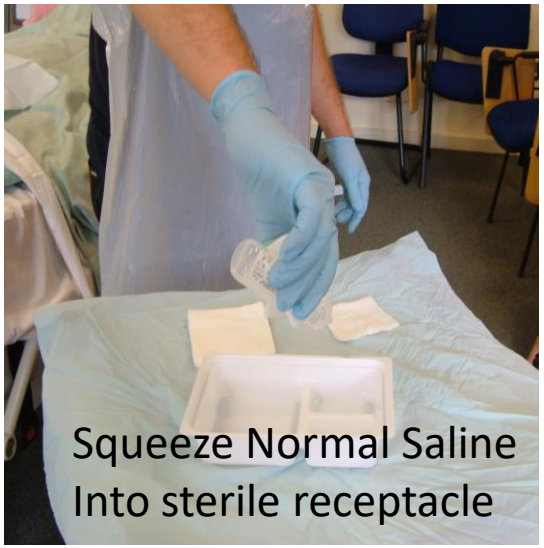






ANTT Wound Cleansing

Use sterile gauze to hold cleansing pod



Clean around wound
in one continuous swoop

Dirty hand disposes into dressing disposal bag

ANTT – Applying the Dressing

ANTT – Waste Disposal

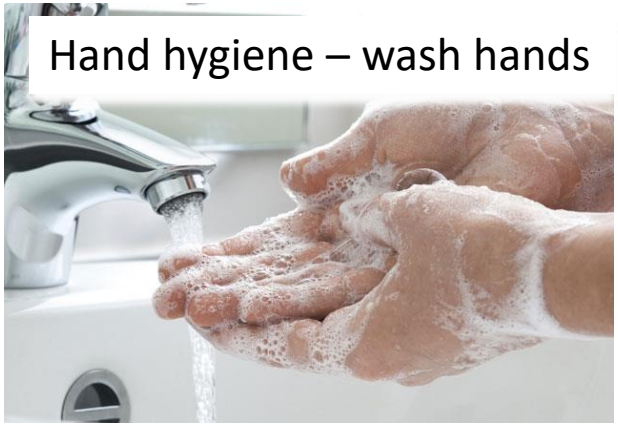
Wrap up pack & contents

Place in dressing disposal bag

Remove PPR & place in disposal bag

Decontaminate work surface

Place in clinical waste



Hand hygiene – wash hands

ANTT – Post Procedure