Wound Care

promoting healthy skin

Champions for Skin Integrity

These guidelines have been developed for health professionals caring for clients with wounds. Assessment and management of wounds should be undertaken by health professionals with expertise in the area.

GUIDELINES SUMMARY

For this summary, all recommendations have had their levels of evidence classified using the National Health and Medical Research Council levels of evidence, as follows:

Level I	Evidence from a systematic review or meta-analysis of at least two level II studies
Level II	Evidence from a well designed randomised controlled trial (for interventions), or a prospective cohort study (for prognostic studies)
Level III	Evidence from non-randomised studies with some control or comparison group (pseudo-randomised controlled trial; non-randomised experimental trial, cohort study, case-control study, time series studies with a control group; historical control study, retrospective cohort study)
Level IV	Evidence from studies with no control or comparison group

An additional rating of Expert Opinion (EO) has been added, for guideline recommendations which are consensus statements provided by a National or International Panel of experts in the area.

This is a summary of guidelines from the following sources, which should be accessed for further details as required:

1. World Union of Wound Healing Societies. *Principles of best practice: Minimising pain at wound dressing-related procedures. A consensus document.* London: MEP Ltd 2004. www.woundsinternational.com/pdf/content_39.pdf
2. Australian Wound Management Association. *Standards for wound management.* 2nd ed. Osborne Park, WA: Cambridge Media 2010. www.awma.com.au/publications/2011_standards_for_wound_management_v2.pdf
3. The Wound Healing and Management Node Group. Chronic wound management. *(JBI) Best Practice:* 2011. http://connect.jbiconnectplus.org
4. Australian Wound Management Association. *Position Document: Bacterial impact on wound healing: From contamination to infection.* AWMA 2011. www.awma.com.au/publications/2011_bacterial_impact_position_1.5.pdf
5. Hopf H et al. Guidelines for the treatment of arterial insufficiency ulcers. *Wound Repair and Regeneration* 2006. 14(6): 693-710. http://onlinelibrary.wiley.com/doi/10.1111/j.1524-475X.2006.00177.x/pdf
6. World Union of Wound Healing Societies. *Principles of best practice: Wound exudate and the role of dressings. A consensus document.* London: MEP Ltd 2007. www.woundsinternational.com/pdf/content_42.pdf
7. Medical Advisory Secretariat. *Community-based care for chronic wound management: An evidence-based analysis.* Ontario Health Technology Assessment Series 2009. 9(18). www.health.gov.on.ca/english/providers/program/mas/tech/reviews/pdf/rev_smcc_wound_20091019.pdf
8. Fernandez R, Griffiths R. *Water for wound cleansing.* Cochrane Database of Systematic Reviews 2012(2). http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003861.pub3/pdf
9. Whitney J et al. Guidelines for the treatment of pressure ulcers. *Wound Repair and Regeneration* 2006. 14(6): 663-679. http://onlinelibrary.wiley.com/doi/10.1111/j.1524-475X.2006.00175.x/pdf
10. *Best Practice Statement: The use of topical antiseptic/antimicrobial agents in wound management.* 2nd ed. Wounds UK 2011. www.wounds-uk.com/best-practice-statements

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Assessment

1. Assessment and wound management should be carried out by staff with training, skills and experience in wound care[1] (EO)
2. Assess and document: physical examination, medical history, social history, psychological well-being, nutritional status, pain (include a pain scale), history of previous wounds, current wound duration, site, current and previous wound treatments[2] (EO)
3. Assess, classify and document wound size, shape, depth, tissue type, colour, odour, exudate, wound margin, surrounding skin and tissue condition[2] (EO)
4. Assess and document signs of infection: cellulitis, erythema, malodour, increased pain, delayed healing, deterioration of the wound, purulent exudate[2] (IV)
5. Reassess and document progress in healing regularly [3], including evaluation of the response of the client and wound to any treatment for wound infection[4]
6. Ongoing assessment of pain should be performed before, during, and after each dressing procedure;[1] (EO)
   using a standardized assessment tool[1] (IV)
7. Referral for specialist treatment may be necessary if there is:
   - failure to progress to heal
   - unexpected change in level or type of exudate
   - unexpected change in level or type of pain
   - there is uncertainty in diagnosis
   - signs of infection
   - the ulcer appears ischemic[1,5,6] (EO)

Management

8. Managing chronic wounds with a multidisciplinary team promotes wound healing and reduces severity of wound-associated pain and frequency of wound treatments[7] (III)
9. Strategies for minimising infection risk should be embedded in a wound management plan[4] (EO)
10. Acute and chronic wounds may be cleansed using potable tap water if normal saline is unavailable[8] (I)
11. The ulcer should be irrigated with a neutral, non-irritating, non-toxic solution, and cleansing undertaken with minimal chemical or mechanical trauma[9] (IV)
12. Removal of necrotic and devitalised tissue should be undertaken through mechanical, sharp, autolytic or biological debridement[9] (II)

    * If dry gangrene or eschar is present, however, debridement should not be undertaken until arterial flow has been re-established[5] (III)

13. A moist wound environment should be maintained for optimal healing[2] (IV)
    A moist wound environment promotes healing by enabling migration of tissue-repairing cells and spread of immune and growth factors. Extreme wetness or dryness may delay healing[6] (IV)

14. Dressings should:
    - maintain a moist wound-healing environment[2,3] (IV)
    - manage wound exudate and protect peri-ulcer skin[6] (I)
    - remain in place and minimise shear, friction, skin irritation and pressure[9] (II)
    - be non-adherent to reduce trauma on removal[1,6] (EO)
    - however, dry gangrene or eschar is best left dry until revascularisation[5] (III)
15. Dressings should be cost effective, acceptable to the client and able to be changed once per day or less often when possible[1,6] (II)
16. A topical antimicrobial agent should be used in clients with critically colonised, localised or spreading wound infection;[4] (III) the length of treatment should be determined by the response of the wound and the client[4] (EO)
17. Adequate oxygenation of the wound environment will promote healing, and should be promoted through avoidance of dehydration, cold, stress and pain[5] (III)
18. Effective pain management strategies should be implemented to minimise pain during wound dressing procedures[1] (EO)
19. Maintain optimal levels of nutrition[3] (II)
20. Provide client education on all aspects of wound management[6] (EO)
21. Promote psychosocial support[6] (EO)