QUALITY PROCEDURE

COMMUNITY CARE SERVICES
HOME CARE PROGRAM

WOUND MANAGEMENT PROCESS
REGISTERED NURSE

1.0 OBJECTIVE

To inform all clinical staff involved in wound management practise to promote wound healing and/or in the case of chronic or palliative wound management, provide comfort and minimise wound complications. This is achieved by holistic assessment of the Client and their wound. The Clients relatives/EPOA will be kept informed during the process. Wound re-evaluation is ongoing and facilitates clinical decision-making; intervention and education which will minimise complications, aid optimal wound healing and promote Client comfort and quality of life.

2.0 RESPONSIBILITIES

2.1 The Chief Executive Officer or nominated representative is responsible for providing adequate resources to ensure that wounds will be assessed and managed effectively.

2.2 The Director of Home Care and Disability is responsible for ensuring that Clients wounds are assessed and managed effectively, and that Clients are treated with dignity and respect. The Director of Home Care and Disability is responsible for ensuring that staff conduct themselves in a professional manner and adhere to this procedure.

2.3 All clinical staff who attend wound management are: responsible at all times for the assessment of the wound, development of appropriate wound management plan, completion of the wound assessment chart and ongoing re-evaluation of wound management plan (in collaboration with the medical team). When nursing staff are involved a Registered Nurse (RN) is primarily responsible to ensure this happens, for dressing reviews the RN will take direction from the Clinical Nurse (CN) or consulting G.P. An Enrolled Nurse (EN) may be delegated specific wound management activities under the direct supervision of the RN.

3.0 DEFINITIONS

<table>
<tr><td colspan="2">Wound management refers to</td><td>Assessment of the Client and their wound
Planned intervention
Regular re-evaluation
Education of Client and family</td></tr>
<tr><td colspan="2">Acute wound</td><td>An acute wound is any surgical wound that heals by primary intention or any traumatic or surgical wound that heals by secondary intention, and which progresses through the healing process (reaction, regeneration and remodelling phases) in an orderly and timely manner that results in sustained restoration of anatomical integrity</td></tr>
<tr><td colspan="2">Chronic wound/non healing wound</td><td>A chronic wound occurs when the healing process does not progress through an orderly and timely process as anticipated and healing is complicated and delayed by factors that impact on the person, the wound or the environment. Also call a non healing wound</td></tr>
<tr><td colspan="2">Palliative wound</td><td>A palliative wound does not have the potential to heal, eg, cancerous wounds</td></tr>
<tr><td colspan="2">Healed wound</td><td>A completely healed wound is one that has totally epithelialized and has stayed healed for a minimum of 28 days</td></tr>
<tr><td colspan="2">Palliative wound management</td><td>Palliative wound management, eg cancerous wounds – if healing is not the expected outcome the focus of management is on aesthetics, comfort, prevention of bleeding and dealing with malodour (usually caused by infection)</td></tr>
<tr><td rowspan="2">Assessment</td><td>Acute</td><td>Accurate and regular, review including assessment of wound area by an RN at dressing changes</td></tr>
<tr><td>Chronic</td><td>Accurate and regular, review including assessment of wound area by RN at dressing changes</td></tr>
</table>

Evaluation	Acute	Evaluation of treatment, management and intervention, at dressing changes by the CN
	Chronic	Evaluation of treatment management and intervention at least monthly by the CN
Referral		A referral to the wound specialist or GP should be undertaken by the CN
Education – Resident/family/EPOA		Education should be timely and continuous throughout the healing process and should include a maintenance plan. The information should be both verbal and written where necessary.

4.0 PROCEDURE

4.1 Assessment

4.1.1 A referral to a wound specialist by the CN should be undertaken/considered when a wound is not healing and/or the wound is complicated by an underlying clinical condition, for example, diabetes, or in the clinical judgement of the clinical team it is warranted.

4.1.2 The wound assessment and management process will involve the establishment of a management plan outlining the initial wound assessment, client wishes, availability of supply, cost of dressing, management plan and ongoing re-evaluation. This plan will be kept within the Clients in home record and within the electronic medical record.

4.1.3 Review the Clients medical history to identify any underlying medical problems that may impede the healing process. If aetiology of the wound has not been defined, immediate steps must be taken to have this investigated. Factors that may affect wound healing are;

- Wound trigger: surgical, trauma, pressure, infection, oedema, previous treatments
- Medical history: conditions that affect the blood flow to the wound such as diabetes, anaemia and cardiovascular disease
- Nutritional status: lack of nutrition is linked to impaired wound healing
- Environmental factors: Clutter, pets, use of hoists
- Psychological factors: stress and cognitive impairments
- Other: smoking, incontinence, immobility and pain

4.1.4 A comprehensive wound history must be obtained and documented

4.1.5 An assessment of the wound will be made using the area Wound Care record (Appendix A) or similar e-based assessment prior to dressings being applied to a wound. The wound assessment will include the following descriptions;

- Date of wound assessment
- Wound location
- Wound size
- Wound shape
- Wound depth
- Tissue type in the wound, surrounding the wound and peri wound area
- Any undermining
- Odour
- Heat

- Description and volume of exudate
- A photo will be taken at initial assessment

4.1.6 A description of the wound will be used in monitoring the progress healing / or the deterioration of the wound. Photos must be taken at each wound revaluation.

4.1.7 Address any immediate wound concerns identified e.g. uncontrolled excessive bleeding of wounds, re-evaluation of the wound/s will occur weekly of an acute wound, monthly for a chronic or palliative wound. This re-evaluation process must be documented to provide evidence of wound healing or deterioration. Individualised Assessment and Management plans will be reflective of the assessments and must include all aspects of the wound care needs

4.1.8 When assessing the wound differentiate between inflammation and infection. On an acute wound, inflammation stage will occur 3-5 days post wound, where the capillaries are dilated to allow the white cells to remove debris by phagocytosis, inflammation should reduce by day 3. The following signs and symptoms will be present in infection

- Redness extending 2-3cm outside the wound margin
- Heat (with or without swelling/oedema)
- Odour
- Pain
- Increased exudate with a change in colour, viscosity and type
- Delayed healing or wound breakdown
- Wound bed discolouration/granulating tissue which bleeds easily
- Pocketing at the base of the wound

4.1.9 Appropriate referrals should be made within the multidisciplinary team. As optimal healing is promoted by collaboration between all clinical staff involved in wound management

4.1.10 Nutritional supplements, for example, arginaid or zinc based products, will only be used when there has been collaborative decision has been made which includes the GP, DoC and/or CN

4.1.11 Provide client and their relatives/EPOA with information on the wound assessment outcomes including wound type and treatment / potential care options

4.2 Management and Evaluation

4.2.1 Every endeavour must be made to identify factors affecting the healing process. These must be addressed where possible. All clinicians must monitor the wound for symptoms of infection and failure of the wound to respond to appropriate topical treatment. If a wound is noted to be non-healing or infected the clinician must ensure the appropriate action is taken and referrals made.

4.2.2 Any bleeding wound is to be managed with a haemostatic dressing product.

4.2.3 Escalate uncontrolled excessive bleeding wounds to Registered Nurse and Case Manager for immediate review by the Clients General Practitioner.

4.2.4 Wound management dressings, pharmaceuticals and devices are to be used in accordance with the manufacturer's instructions or research protocols.

4.2.5 Wound management is practiced in accordance with the best available evidence for optimizing healing in acute and chronic wounds.

4.2.6 Clients choice not to follow treatment plan must be recorded in the client in home and electronic medical record indicating the reason for their decision.

4.2.7 Advise them to be alert to signs and symptoms of any contrary reactions / discomfort to treatment or when to ask for additional assistance.

4.2.8 Client and their relatives/EPOA should be provided with appropriate handouts to reinforce teaching/learning. Where possible, translations should be provided for non-English speaking clients and carers.

4.3 Skin Tear Management

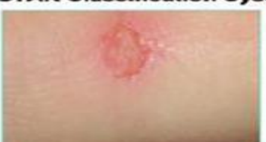
4.3.1 First aid

- If a skin tear occurs and can't be immediately assessed by the RN the following first aid actions may take place that adhere to protection and moisture protocols.
  - Pressure
    - A damp clean wash is applied
    - Area is wrapped in cling film
  - Elevation
  - Report
  - Document
  - Dress if appropriate

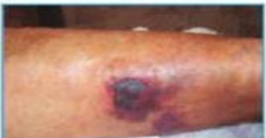
4.3.2 Skin tear is to be managed by using the STAR acronym and classification system;

- S- Stop the bleeding and clean
  - Select an appropriate cleanser
  - Assist in bleeding control
  - Clean the wound bed
- T – Tissue Alignment
  - Align the skin flaps (if possible) over the wound bed
- A – Assess and dress
  - Complete a holistic health assessment
  - Inspect the surrounding skin
  - Categorise the skin tear according to the STAR classification (appendix B)
  - Draw an arrow on the dressing, indicating the direction of the skin flap
- R - Review and re-assess
  - If the skin flap is pale and dusky/darkened, reassess within 24-48 hours
  - Document the determined date of review and dressing change
  - Remove the dressing in direction of the arrow
  - Monitor for changes in the wound status by observing the wound pictures
  - Assess maintenance of the overall skin integrity

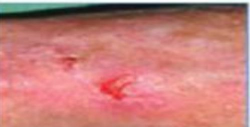
STAR Classification System



Category 1a
A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened.

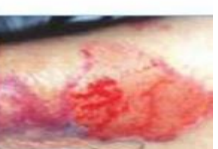


Category 1b
A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened.



Category 2a
A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky or darkened.

Category 2b
A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened.



Category 3
A skin tear where the skin flap is completel absent.

4.4 Pressure Area Care Management

4.4.1 Pressure injury is caused by unrelieved pressure of the tissue that is compressed between a bony prominence and an external surface either through shear, friction force or moisture. This leads to the occlusion of the vascular and lymph node vessels that supply oxygen and nutrients to the tissue.

4.4.2 The following risk factors have been found to contribute the development of pressure sores;

- Frail persons
- Immobility
- Impaired sensation or impaired ability to respond to pain or discomfort
- Malnutrition
- Obesity
- Circulation disorders
- Smoking
- Alcohol/Drug use

4.4.3 Pressure injuries are classified according to stages;

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin	Stage 4 Pressure Injury: Full-thickness loss of skin and tissue
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis	Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Stage 3 Pressure Injury: Full-thickness skin loss	Deep tissue pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration

4.4.4 Pressure Injury Management. Staff in direct care of the client who is at risk of developing pressure sores should adhere to the client's skin integrity care plan. Some of the preventative measures that can be incorporated in the client's care to reduce the risk of developing pressure sores or further break down, may include;

- Regular position changes (wheelchair bounded clients- reposition every 30 mins and bed bounded clients every 2 hours and to avoid putting pressure on the hip bone)
- Pillows and hip protectors should be used as a soft buffer between the skin and the surface of the bed or chair
- Use special mattresses and beds
- Perform skin inspection every time care is delivered to monitor signs of redness or discolouration.
- Ensure the skin is not too dry or too moist
- Apply moisturising creams to ensure the skin is supple
- Avoid message in bony areas as the skin can be delicate
- Ensure that the client has a nutritious diet and that weight is monitored at least monthly
- Ensure good hygiene practice around the perianal and sacral region
- Encourage the client to maintain activity levels where appropriate
- Encourage the client to quit smoking with support and assistance
- Apply dressings over the sores to ensure the wound bed is moist and the surrounding skin dry and that their skin temperature is stable
- Light packing of empty skin spaces with dressings to prevent infections
- Apply specific topical medications as prescribed by the GP or wound specialist, if the wound is infected

4.4.5 The goals in the management of wounds are;

- Reduce the pressure and shear forces
- Management of exudate
- Prevention of contamination in the wound by ensuring the principles of clean techniques and hang hygiene is applied during all dressing change
- Create a moist, temperature stable wound environment

4.4.6 The goals on selecting the most appropriate dressing is to;

- Provide a barrier to bacteria
- Absorb excess exudate
- Be atraumatic on removal
- Allow gaseous exchange
- Provide thermal insulation
- Protect the wound from further damage

4.5 Treatment Guidelines

4.5.1 Wound Bed Preparation. The aim of the wound bed preparation is to remove barriers to wound healing by;

- Creating a vasculated wound bed by removing necrotic tissue and slough;
- Reduce the inflammation or infection; and
- Manage the exudate levels to avoid maceration or desiccation.

4.5.2 To prepare the wound bed, the TIME framework is utilised;

- T – Tissue non-viable or deficient
  - Is removal of necrotic/sloughy tissue needed? If Yes:
    - Clinical Action: Remove necrotic tissue or slough present Clinical Process: Debride
    - No mechanical/sharp debridement is to be undertaken without medical officer approval
    - Chemical debridement is undertaken by the use of Acetolytic agents such as solugel

- I – Infection and/or inflammation Is the wound infected? If Yes:
  - Clinical Action: Remove or reduce bacterial load
  - Clinical Process: Topical antimicrobials, debridement of devitalized tissue
- M- Moisture balance. Do I need to hydrate the wound, absorb exudate or maintain exudate? If Yes:
  - Clinical Action: Risk of desiccation. Restore moisture balance Clinical Process: Absorb exudate or add moisture to dry wound
- E- Edge of wound: non-advancing or undermined
  - Clinical Action: Address T/I/M issues and reassess after 2 weeks. If there is minimal improvement, report to the GP and consider referral to the wound specialist nurse.

5.0 REFERENCE DOCUMENTS

Appendix A HCP-F-008 Wound Assessment Form

Appendix B HCP-F-005 Body Diagram Assessment Form

https://www.npuap.org/resources/educational-and -clinical-resources/

https://promoting-healthy-skin.qut.edu.au/

Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010.

https://www.woundsinternational.com/uploads/resources/f4bcdbfac0ac39b4610be85fe0ce38c6.pdf

http://www.woundsinternational.com

WOUND MANAGEMENT REGISTERED NURSE

APPROVED BY:

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CHIEF EXECUTIVE OFFICER

DATE: ______________________________

WOUND ASSESSMENT									
Client Name						Date of Birth			
Client Overview									
Diabetes		☐Yes ☐No		Type and Management					
Smoker		☐Yes ☐No		Anaemia		☐Yes ☐No			
Respiratory illness		☐Yes ☐No		Nutritional status		☐Yes ☐No			
Wound Colour									
Pink – Epithelisation		☐Yes ☐No		Red – Granulating		☐Yes ☐No			
Yellow – Sloughy		☐Yes ☐No		Green – Infected		☐Yes ☐No			
Black – Necrotic		☐Yes ☐No							
Exudate									
Nil	☐	Low <5mls	☐	Moderate <10mls	☐	Heavy ,15mls	☐		
Exudate Type									
Serous	☐	Haemoserous	☐	Purulent	☐				
Surrounding Skin									
Healthy	☐	Dry/Scaly	☐	Fragile/Thin	☐	Oedema	☐	Blistered	☐
Bruised	☐	Inflamed	☐	Cellulitis	☐	Macerated	☐	Necrosis	☐
Wound Dimensions									
Length		Width		Depth					
Photos attached		☐Yes ☐No		Wound Tracing attached		☐Yes ☐No			
Condition of Wound									
New wound	☐	Healed	☐	Improved	☐				
Deteriorated	☐	Intervention	☐	Nil Change	☐				
Pain Assessment and Intervention									
None	☐	Continuous	☐	Intermittent	☐	Dressing change only	☐		
Pain Score		Intervention:							
Cleansing Solution used				Gentle Irrigation		☐Yes ☐No			
Wound Swab									
Has the wound been swabbed		☐Yes ☐No		If yes, date taken					
Results				Sensitivities					
Reported to				Antibiotic required					
If yes, Type and dosage									

Dressings			
Allergies to dressing	☐Yes ☐No	If yes, please specify	
Primary Dressing:			
Secondary Dressing:			
Frequency of dressing change:			
Assessment Completion			
Name of person completing the assessment:			Designation
Date and time assessment completed:		Signature:	
Wound Review			
Wound review date	Checked and left intact ☐Yes ☐No	Dressing attended ☐Yes ☐No	
Primary Dressing:			
Secondary Dressing:			
Frequency of dressing change:			
Comments:			
Assessment Completion			
Name of person completing the assessment:			Designation
Date and time assessment completed:		Signature:	
Wound Review			
Wound review date	Checked and left intact ☐Yes ☐No	Dressing attended ☐Yes ☐No	
Primary Dressing:			
Secondary Dressing:			
Frequency of dressing change:			
Comments:			
Assessment Completion			
Name of person completing the assessment:			Designation
Date and time assessment completed:		Signature:	

Wound Review		
Wound review date	Checked and left intact ☐Yes ☐No	Dressing attended ☐Yes ☐No
Primary Dressing:		
Secondary Dressing:		
Frequency of dressing change:		
Comments:		

Assessment Completion	
Name of person completing the assessment:	Designation
Date and time assessment completed:	Signature:

Wound Review		
Wound review date	Checked and left intact ☐Yes ☐No	Dressing attended ☐Yes ☐No
Primary Dressing:		
Secondary Dressing:		
Frequency of dressing change:		
Comments:		

Assessment Completion	
Name of person completing the assessment:	Designation
Date and time assessment completed:	Signature:

APPENDIX B – BODY DIAGRAM

Assessment Type	☐Pain Assessment ☐ Skin Integrity Assessment ☐ Wound Assessment (tick assessment being completed)	Assessment Date	
Client Name		Date of Birth	
Mark location with "X"			

Left

Right

L

R

L

R

Left

Right

Comments:		
Name:	Designation:	Signature:
Note: Ensure the Body Diagram Assessment document is scanned and uploaded to the client profile in Home Care Manager.		