Wound Management Policy

1. Background

The purpose of this policy is to establish minimum practice standards for the care and management of wounds throughout the WA Country Health Service (WACHS).

Further information relating to specialty areas including burns management (State Wide Burns Service, Child and Adolescent Health Service (CAHS), Women and Newborn Health Services (WHNS) can be found via HealthPoint if not covered in this policy.

2. Policy Statement

Non-surgical wounds acquired in hospital, including: skin tears, pressure injuries or self-harm are reported to the Senior Nursing staff and then via the Clinical Incident Management System (CIMS Datix). Refer to WA Health MP0122/19 Clinical Incident Management Policy 2019.

Where Senior Clinician assistance is required in relation to wound assessment and management, consider the following options where appropriate in relation to the patient's clinical requirements, site specific guidelines and/or available specialised staffing resources:

- Medical Officer, including Specialist Medical Review, General Practitioner
- Senior Nursing Staff, including Wound Management Nurses, Stomal Therapy Nurses
- Allied Health clinicians and specialists.

Inclusions within this policy

- Pin Site Care Addendum (best printed in A3)
- Skin Tear Prevention and Management Addendum (best printed in A3)
- Suture and Staple Removal Addendum

Exclusions to this policy:

- Dermatological conditions, Stoma Management and Pressure Injury and Prevention Management, wound closure by sutures, burns management (Children's, Adults)
- Plastic surgery remains under governance of the surgical team.

2.1 Assessment and Documentation

All inpatients require completion and documentation of a Braden scale assessment and a comprehensive skin assessment within a minimum of eight hours of admission. (Refer to WACHS Pressure Injury Prevention and Management Policy)

Identify any existing wounds or pressure injuries refer to MR111 WACHS Nursing Admission, Screening and Assessment Tool- Adults, MR120 WACHS Adult Nursing

Care Plan; MR124 WACHS Braden Scale and Pressure Injury Risk Assessment, and the MR122 WACHS Wound Assessment and Management Plan.

Outpatients require an MR122 to be completed on each visit.

Where a patient presents with any of the following wound management issues, leave intact and seek guidance from senior clinician:

- Compression bandaging
- Topical negative pressure therapy
- Complex wound drainage system
- Bone, tendon, vessels or structures visible.

2.1.1 Wound Management Plan (WACHS MR122)

In addition to information contained in the Wound Assessment section below, clearly document the following on the wound management plan:

- date of evaluation
- selected dressing
- dressing change frequency
- analgesia requirements

2.1.2 Wound Assessment

Ensure to include the following information to assess and describe the presenting wound:

- aetiology and duration of wound
- anatomical location
- dimensions (length x width x depth)
- wound appearance
- tissue type
- wound edges
- condition of skin surrounding wound
- exudate: amount and type
- odour
- pain assessment
- signs of infection, foreign bodies, debris and dressing remnants if present

Include patient specific factors, such as:

- past medical and/or surgical history
- co-morbid conditions
- medications, and/or current treatments
- function and psychosocial well-being
- smoking status
- nutritional status, including considering referral to Dietitian for complete nutritional assessment[2].

2.1.3 Wound Photographic Images

Where there is intended use of wound photographic images patient consent is required.

Refer to the WACHS Clinical Image Photography and Videography Policy for guidance.

2.2 Patient Monitoring

Individualised management plan to be documented in the healthcare record as soon as is practicable. At a minimum the plan must consider:

- patient history and diagnosis for clinical conditions, medications, psychosocial and cultural factors that could influence observations
- presence of comorbidities and treatment
- frequency and specific observations
- site requirements, patient education and consent
- any restriction to intervention associated with advance health directives (AHD) or Goals of Care (GoC)

2.3 Patient Support Considerations3

Ensure the following considerations are met relating to any wound care interventions:

- The patient, according to their ability:
  - have the chance to understand their wound
  - be involved in the decision making process
  - receive information prior to the intended interventions and give appropriate consent.
- Dressing choice contraindications have been considered.
- Provision and management of appropriate pain assessment and implementation of strategies to minimise the impact of pain.
- Maintain patient privacy and dignity when exposing the wound area.
- Offer the presence of a chaperone or interpreter where appropriate to patient and clinician requirements

Patient resources are available at Healthy WA Wounds webpage

2.4 Wound Infection Prevention Considerations

In conjunction with the information relating to wound infection prevention, refer to:

2.4.1 Personal Protective Equipment (PPE)[4]

Select and include the use of PPE where appropriate to the procedure being undertaken.

Ensure to change the PPE between different care activities for the same patient to prevent cross contamination.

2.4.2 Hand Hygiene[5]

Hand hygiene must be carried out as per WACHS Hand Hygiene Policy.

2.4.3 Standard and Surgical Aseptic Technique [6]

As wound care will vary in complexity, clinical judgement will be required regarding selection for either: standard aseptic, surgical aseptic or clean wound management technique. Please review the WACHS Aseptic Technique Policy when managing wounds.

2.4.4 Wound Management Factors[7]

Other factors associated with minimising the risk of wound infection, may include:

- Optimise patient health conditions and psychosocial factors: management of comorbid conditions, smoking cessation, rest, etc.
- Optimise patient nutritional status: Liaise with Dietitian regarding Medical Nutrition Therapy, special dietary and hydration requirements.
- Provide wound care interventions at optimal frequency; minimise wound bed exposure, and selection of most appropriate wound care products.
- Refer to site specific guidelines and resources in relation to wound care.
- Perform adequate wound cleansing to remove foreign bodies, debris and dressing remnants.
- Appropriate removal of non-viable wound tissue under senior guidance if conservative sharp debridement is required.
- Assess for clinical signs and symptoms of wound or systemic infection.
- Refer to allied health services as appropriate.

2.5 Wound Cleansing

2.5.1 Wound Care Environment

Ensure to restrict activities around the patients bed or treatment area to reduce environmental cross contamination, this may include bed making or room cleaning activities[6].

When selecting a surface to prepare and set wound care equipment, use clinical judgement in relation to the:

- complexity of the wound
- patient condition
- environment
- requirements for maintaining principles of aseptic technique
- suitable options (resources) available of the treatment surroundings.

Consider the personal and clinical requirements of the patient in relation to wound care. Refer to Patient Support Considerations section 2.3.

2.5.2 Cleansing Solutions

When selecting a solution for cleansing the wound, use clinical judgement in relation to the complexity of the wound, patient condition and pain.

Consider the following information:

- Sodium chloride 0.9%.
- Cleansing acute and chronic wounds with potable water does not increase infection rates[8].

A risk assessment must take place prior to washing or showering of wounds[7].

- Wounds not suitable for cleansing in the shower include wherever vessel, bone, tendon or other underlying structures are in view.
- When the patient is immunocompromised.
- Do not wash any wounds in multi patient en-suites (wounds can only be washed in private en-suite).

For infected and chronic wounds consider cleansing with a suitable antiseptic agent as directed by wound specialists and manufacturer's instructions.

2.5.3 Equipment Required

For specific advice regarding wound care products refer to site specific wound management services where available.
Advance wound care treatment (such as Silver Nitrate applications) to be directed by a wound care specialist.
Wound care products are generally limited to those items available on the current procurement tender. Specific wound dressing products not available on tender may be ordered with manager approval.

All sterile wound care products are intended for single use only use only or as per manufacturer instructions for use

2.5.4 Diagnostic Investigations[2]

Consider undertaking diagnostic investigations where clinically indicated to assist with ascertaining and monitoring the wound[7]:

- aetiology
- associated diagnosis
- healing potential
- management interventions
- assessment outcomes
- suspected infection
- non-healing wounds to be referred for further investigation and management.

2.5.5 Discharge Planning

Ensure to anticipate and plan continuity of wound management for those patients being discharged either across the continuum of clinician provided care, or to self-care.

Where patients require wound care on discharge to clinical service provided care (e.g. Silver Chain), consider the following requirements:

- ensure referral and current wound management plan are supplied to service provider
- Provide dressing products on discharge as per local site instruction with consideration of patient's destination.

Provide information to the patient regarding:

- Any follow-up appointments, and/or service referrals.

Provide education to the patient regarding reporting to General Practitioner/ service provider in relation to adverse signs and symptoms:

- infection
- wound deterioration
- other clinical concerns, e.g. pain or bleeding.

Refer also to WACHS Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard.

3. Definitions

Acute wound	a wound of less than six weeks duration that progresses through the phases of healing without delay
Aseptic technique	a technique that aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Unlike sterile techniques, aseptic techniques can be achieved in typical ward and home settings.
Chronic wound	a wound that deviates from expected sequence of repair in terms of time, appearance and response to appropriate treatment; and does not demonstrate significant signs of healing in six weeks.
Delayed healing	Healing progresses at a slower rate than expected. As a guide[3] • in open surgical wounds healing mainly by epithelialisation, the epithelial margin advances at about 5mm per week • clean pressure ulcers with adequate blood supply and innervation should show signs of healing within two to four weeks • a reduction in venous leg ulcer surface area of >30% during the first two weeks of treatment is predictive of healing."
Full thickness wound	a wound where tissue damage extends beyond the skin and extends at least into the subcutaneous layer. Tissue damage may also extend to muscle, tendon and/or bone.
Skin integrity	may relate to the normal function of skin as complete healthy tissue, without injury or breaks in continuity
Skin tear	is a traumatic wound occurring principally on the extremities of older adults, as a result of friction alone or shearing and friction forces which separate the epidermis from the dermis (partial thickness wound) or which separate both the epidermis and the dermis from underlying structures (full thickness wound).
Wound	an occurrence where skin integrity has become injured or broken in continuity[1].

4. Roles and Responsibilities

All Staff are:

- required to work within their scope of practice
- responsible for adhering to processes in this policy and associated procedures to ensure optimal wound assessment and management in WACHS health care facilities.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

Failure to accurately and legibly record, and understand what is recorded in patient health records contribute to a decrease in the quality and safety of patient care. Document the outcome of all assessments, and interventions in the patient health record, including site specific wound management plan. Refer to WACHS Documentation Clinical Practice Standard.

7. Evaluation

Evaluation of this policy is to be carried out by the WACHS Wound Management working party.
The following means or tools are to be used:

- CIMS forms

Compliance with aseptic technique is monitored by CoBRA audits.

8. Standards

National Safety and Quality Health Service Standards: 3.9, 5.21

9. Legislation

Heath Services Act 2016 (WA)

10. References

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5. Hand Hygeine Australia. Instructions for healthcare workers. 2019. https://www.hha.org.au/hand-hygiene/hha
6. Wounds Australia. Application of aseptic technique in wound dressing procedure A consensus document. Cambridge Media: Osborne Park, WA; 2020
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11. Related Forms

MR111 WACHS Nursing Admission, Screening and Assessment Tool – Adults
MR120 WACHS Adult Nursing Care Plan
MR122 WACHS Wound Assessment and Management Plan
MR124 WACHS Braden Scale and Pressure Injury Risk Assessment
MR124B WACHS Comprehensive Skin Assessment

12. Related Policy Documents

WACHS Pressure Injury Prevention and Management Policy
WACHS Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard
WACHS Aseptic Technique Policy
WACHS Clinical Image Photography and Videography Policy
WACHS Documentation Clinical Practice Standard
WACHS Hand Hygiene Policy
WACHS Infection Prevention and Control Policy
WACHS Nutrition Clinical Practice Standard
WACHS Stoma Management Clinical Practice Standard
WACHS Suture and Staple Removal Addendum
WACHS Pin Site Care Addendum
WACHS Skin Tear Prevention and Management Addendum
ANZ Clinical Practice Guideline for Prevention and Management of Venous Leg Ulcers

13. Related WA Health System Policies

MP0122/19 Clinical Incident Management Policy 2019
WA Pressure Injury Prevention and Management Clinical Guideline

14. Policy Framework

Clinical Governance, Safety and Quality

This document can be made available in alternative formats on request for a person with a disability

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