



Complex Wound Management Policies & Procedures

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COMPLEX WOUND MANAGEMENT

Scope

When

- Applies when clients are supported with complex wounds

Who

- Applies to all employees, supervisors and key management personnel supporting clients with complex wounds

Purpose

When supporting clients with complex wounds, it is important to provide consistent individualised support as there are physical, psychological, and social impacts of living with a wound. Wounds can cause pain, systemic illness, increased time in hospital, extended absence from normal activities, low self-esteem and altered body image.

A person's wounds can be interfered and /or affected by:

- Medication – drugs that suppress the immune system or thin the blood
- Age – being elderly means risk of infection is higher, scar tissue is more fragile and other health conditions are more likely
- Smoking (including passive smoking) – increased risk of infection, dampened inflammatory response and hypoxia (deficiency in the amount of oxygen reaching the tissues)
- Decreased mobility/lack of exercise – particularly a lack of ankle mobility can result in lower limb oedema or venous congestion and ulceration
- Obesity – increases risk of wound dehiscence and infection and venous hypertension
- Inappropriate dressings – adherent dressings can cause damage while other dressings stay too wet or interfere other ways
- Rough handling of the wound – new granulation or epithelium may be damaged
- Poor general health – other health conditions can cause hypoxia or impede or delay healing

Wound healing can be complex and is affected by numerous general and local factors. With this in mind, it is important to support the whole person and not just treat the wound.

Palliative care

Where palliative care is being provided, healing is not the primary aim. The goal then is to ensure comfort, freedom from pain, itch, malodour, and haemorrhage.

Wound assessment

Wounds should be assessed for any local barriers to healing and the results documented at each dressing change using the following TIME assessment tool. The TIME abbreviation is a summary of the principles of wound bed preparation. It can be used as a memory-aid to guide practice, heal wounds quickly and help clients have a more comfortable path to healing.

	Wound factors	Clinical action	Wound healing outcome
T	Tissue non-viable Necrotic tissue or slough present	Remove defective tissue Debride	Viable (vascularised) wound bed
I	Inflammation and/or infection Increased exudates, surface discolouration or increased odour	Remove or reduce bacterial load Antimicrobial dressings debridement of devitalised tissue	Reduced bacterial burden and inflammation
M	Moisture imbalance Heavy exudates – risk of maceration. Dry wound bed – risk of desiccation	Restore moisture imbalance Absorb exudates, or add moisture to dry wounds	Optimal moisture balance
E	Edge of wound non-advancing or undermining e.g., chronic wound with prolonged inflammation	Reassess T, I and M If no longer an issue, consider alternative therapies to kick-start healing	Restoration of appropriate pH level and cell migration to advance wound edge If wound still static after 2-4 weeks reassess intervention or refer for specialist treatment

Wound cleansing

The aim of wound cleansing is to remove gross contamination with minimal pain to the person and minimal trauma to the tissue. Wounds should be cleaned to:

- Remove excess exudates
- Remove slough and/or necrotic tissue
- Remove remnants of previous dressings

- Facilitate accurate assessment of the wound/wound bed
- Promote patient comfort

Wound infection

It's important to recognise the distinction between contamination, colonisation and infection when supporting a client with complex wounds.

Contamination is when small numbers of bacteria are detected in a wound, but their presence is short lived, and they are not multiplying.

In a colonised wound, bacteria not only increases but have become established. Once an infected wound passes critical colonisation, it may start having an effect on wound healing.

Wound dressing

When selecting dressings, a moist environment at the wound/dressing interface should be selected. The wound dressing product should be appropriate to meet the needs of the wound and/or promote the next stage of the wound-healing matrix, taking into account TIME.

In wound care, accurate assessment of pain is essential with regard to choice of the most appropriate dressing. Assessment of pain before, during and after the dressing change can provide vital information for future wound management. The exception is a person with peripheral neuropathy who may have lost sensation and therefore not able to feel pain e.g., diabetic patients may be unable to feel pain in the foot.

In general, pain experienced by a person, although subjective and variable from person to person, falls into the following categories:

- A deep dull constant pain
- A superficial burning type pain
- A neuralgic type pain
- An ischaemic type pain
- Pain resulting from cellulites

Whatever the cause of the pain, the person's perception should be acknowledged and appropriate action taken to alleviate the pain. The wound dressing should be appropriate to the type, location, and size of the wound.

Any wound dressing with leakage or strikethrough causing a break in the barrier that the dressing provides to external contamination should be changed. If it's not possible to change the dressing in a timely manner, then establish appropriate physical barriers with application of dressing pad over area of strikethrough. If leakage or strikethrough occurs frequently, it may be appropriate to re-evaluate the dressing product choice.

The effectiveness of the selected dressing product should be evaluated after one week unless there is an adverse reaction to the dressing product. Any suspected adverse reaction from the wound dressing product should be reported using the Manage incident process.

Chronic wounds

A chronic wound is one that fails to follow the normal model of acute wound healing, resulting in delayed or halted closure. Chronic wounds require:

- Managing or treating the underlying causes
- Assessing and addressing local barriers to wound healing using TIME
- Assessing and addressing wider factors delaying healing

Examples of chronic wounds include:

- Leg ulcers
- Pressure ulcers (also called pressure sores, bed sores or decubitus ulcers)
- Diabetic foot ulcers

Chronic wounds can sometimes require hospitalisation (especially diabetic foot ulcers).

Exudate control

Controlling exudate is important for comfort, odour and prevention of maceration and excoriation to the surrounding skin. Controlling exudate may include:

- A stoma pouch (subject to advice by a specialist health professional)
- Suitable absorbent dressings
- Skin barrier films or creams to protect surrounding skin

When changing dressings, assess exudate-handling capabilities of dressings and consider with the person if dressing or frequency of dressings needs to be reviewed.

Odour control

Odour is often related to the presence of sloughy or necrotic tissue, which often leads to an increased bacterial burden further contributing to problems with odour.

The most effective way to resolve odour is to treat the cause with debridement and/or reduction of bacterial burden. However, this may not be possible or appropriate with every person. Autolytic debridement by maintaining a moist environment is likely the most appropriate method.

Reducing bacteria levels may involve:

- Systemic antibiotics
- Topical antibacterial
- Antiseptic dressings (may increase pain)

Odour may also be masked by charcoal dressings, regular dressing changes, well-sealed/contained dressings and use of deodorisers or essential oils applied to the top layer of dressings.

Bleeding

Preventing bleeding is a key goal when supporting a person with complex wounds.

This is generally achieved by:

- Careful dressing application and removal
- Maintaining a warm, moist wound bed
- Gentle cleansing techniques

Psychosocial issues

A person with complex wounds has to deal with not only the pain and discomfort of the wound but also altered body image, reduced mobility, and likely deteriorating health. Its important to involve the persons family, friends, and carers according to the persons wishes.

Pain management

Severe pain can contribute to poor wound healing, so pain management is essential.

Assessing a person's pain requires considering:

- Wound site
- The frequency of occurrence
- The type of pain
- The severity of pain
- Anu relieving or exacerbating factors
- Any present analgesia and frequency of administration

Knowing this helps identify the likely cause of the pain and how best to manage it. Managing pain may be pharmacological and/or non-pharmacological depending on the situation.

Employees should seek advice from a health professional regarding pain relief for a person with complex wounds. Comprehensive pain management is outside the scope of this policy.

Definitions

Term	Definition
Analgesia	A medicine that relieves pain
Autolytic debridement	A form of debridement which uses the body's own natural healing mechanism of enzymes and moisture to break down dead tissue over time
Debride	To cleanse by debridement
Debridement, wound debridement	Debridement is the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue. Removal may be surgical, mechanical, chemical, autolytic or by maggot therapy

Dehiscence	Wound dehiscence is a surgical complication in which a wound ruptures along a surgical incision
Excoriation	Where skin is scraped, chafed, or abraded
Exudates	A mass of cells and fluid that seeps out of blood vessels or an organ, especially in inflammation
Fibroblasts	The main connective tissue cells in the body
Fungating wound	A type of skin lesion that is marked by ulcerations (breaks on the skin or surface of an organ) and necrosis(death of living tissue) usually with a bad smell
Hypoxia	A deficiency of oxygen reaching the tissues of the body
Maceration	The softening and breaking down of skin resulting from prolonged exposure to moisture
Perfusion	The passage of fluid through the circulatory system of lymphatic system to an organ or tissues, usually referring to the delivery of blood to a capillary bed in tissue
Slough	Dead tissue separating from living tissue especially a mass of dead tissue separating from an ulcer
Venous hypertension	A condition where the blood leaks downward due to the effect of gravity through leaky one-way valves in leg veins. Can also be due to obesity, previous thrombosis (clotting) or compression of abdominal or pelvic veins

Holistic wound assessment

Holistic wound assessment should be:

- Person centred
- Accurate and precise
- Able to detect the presence of complications
- Able to detect other factors which may delay healing e.g., nutritional status, diabetes, chronic infection, and concomitant medication e.g., steroids
- Able to provide a framework to monitor the stages of wound healing
- Evaluate the effectiveness of any treatment

Local wound assessment should be carried out at least monthly and take into account:

- Type of wound
- Location of wound

- Stage of healing – using a recognised scale e.g., pressure ulcer category 1-4, ungraded
- Wound dimensions – length, width, depth, position/extent of sinuses, undermining of surrounding skin

The client's nutritional requirements should also be assessed to ensure appropriate nutritional needs.

Consultation with a dietitian may be necessary if the client is at risk of malnutrition.

Inflammation and infection control

- Follow standard clinical infection control procedures
- Maintain good hand hygiene practices
- Follow waste management policy
- Systemic antibiotic use should only be decided by a medical practitioner

General care of clients with complex wounds

- Surgical debridement should only be conducted by a qualified and competent health professional
- Always choose appropriate and comfortable wound dressings that are trauma free on removal and take into account odour and the persons culture and beliefs
- Always follow manufacturers instructions when using wound dressings
- Combine primary and secondary dressings from the same manufacturer where possible to avoid possible biochemical reactions of combining interactive dressings
- General use of antiseptics/disinfectants is not recommended as these are shown to kill fibroblasts and thus hamper healing
- If a wound fails to respond to treatment, seek advice from a medical practitioner

Key management personnel responsibilities when supporting clients with complex wounds

- Ensure employees have current knowledge and a training plan to teach the standards of care for clients with complex wounds
- Provide employees education to provide excellent confident care
- Ensure employees follow the Manage complex wound process
- Ensure employees comply with the Medication policy

Employee responsibilities when supporting participants with complex wounds

- Work within their scope of practice and qualifications
- Adhere to hand hygiene and infection control policies
- Recognise the distinction in a wound between contamination, colonisation, and infection
- Recognise when a normal inflammatory process, when it becomes abnormal and when it is due to infection
- Able to confidently assess, cleanse and dress complex wounds as appropriate
- Report incidents via the incident reporting system

Further Advice or Assistance

Further advice and information can be obtained from the:

» Director:

- by phoning: 07 4361 6848;
- by emailing: admin@123supports.com

Effectiveness and Review

The Director will review this Policy and Procedures document each 12 months on the anniversary of its approval.