



**This is a guide only and does not
replace clinical judgment**

References:

WUWHS. Principles of best practice: Minimising pain at wound dressing-related procedures. London: MEP Ltd 2004

Wounds Australia. Standards for Wound Prevention and Management. 3rd ed. Cambridge Media: Osborne Park, WA; 2016.

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

Fernandez R and Griffiths R. Water for wound cleansing. Cochrane Database of Systematic Reviews 2012(2): CD003861. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003861.pub3/pdf>

European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Haesler E (Ed.) 2019: EPUAP, NPIAP, PPIA

World Union of Wound Healing Societies (WUWHS).

Consensus Document. Wound exudate: effective assessment and management, Wounds International, 2019.

www.woundsinternational.com

Gould L, et al. Wound Healing Society 2015 update on guidelines for pressure ulcers. Wound Repair Regen 2016; 24: 145-62.

International Wound Infection Institute (IWII) Wound infection in clinical practice. Wounds International 2016.



60 Musk Ave
Kelvin Grove Qld 4059
Brisbane, Australia

Phone: + 61 7 3138 6000
Email: ihbi@qut.edu.au
Email (Wound Healing): woundresearch@qut.edu.au

CRICOS No. 00213J

www.qut.edu.au/ihbi

This project was funded by the Australian Government Department of Health and Ageing under the Encouraging Better Practice in Aged Care (EBPAC) program.

Wound Care

Information for health professionals



Wound Care

Assessment

- Wound assessment should be undertaken by trained, experienced health practitioners
- Assess and document:
 - physical examination
 - psychological well-being
 - nutritional status
 - pain (including use of a pain scale)
 - history of previous wounds
 - current wound duration, site, treatments
 - wound characteristics: aetiology, size, shape, depth, tissue type, exudate, margin, surrounding skin, signs of infection
- Reassess and document progress in healing regularly
- Reassess pain before, during and after each wound dressing using a standardised assessment tool



A moist wound environment enables migration of tissue repairing cells. Extreme wetness or dryness may delay healing.

- Refer to a specialist if there is:
 - uncertainty in diagnosis
 - management needs outside available skills
 - deterioration or failure to progress to heal
 - unexpected change in level or type of pain or exudate
 - signs of infection or ischaemia

Management

- Multidisciplinary management promotes healing and improved outcomes
 - Gently cleanse wounds with a neutral, non-toxic solution with sufficient pressure to cleanse without damage (4-15 psi)
 - Remove necrotic and devitalised tissue through mechanical, sharp, autolytic or biological debridement
 - If dry gangrene or eschar is present, do not debride until arterial flow is re-established
- *Debridement should only be undertaken by health professionals with expertise in the area*



- Use a topical antiseptic agent in clients with signs of local infection; the length of treatment determined by the response—consider a two-week trial. Topical antibiotics are not recommended. If spreading infection or sepsis occurs, refer for investigations and add targeted systemic antibiotics.
- A moist wound environment should be maintained for optimal healing
- Dressings should:
 - maintain a moist wound environment
 - manage wound exudate and protect the peri-ulcer skin
 - minimise friction, shear, skin irritation and pressure
 - address bacterial bioburden
 - be non-adherent to reduce trauma
 - be cost effective and acceptable to client
- Implement effective pain management during wound dressings
- Encourage optimal levels of nutrition
- Provide education on wound care
- Address client concerns and provide psychosocial support