WOUND MANAGEMENT GUIDELINE SUMMARY
August 2018

Assessment & Determination of Goal of Care

Client Concerns
- Understanding of wound healing / risk factors; adherence to care plan.
- Impact on daily life / body image / QoL issues
- Psychosocial / financial / mental health / cognitive concerns & supports
- Impact of current environment
- Client / family preferences

Wound Pain
- Assess before, during, post care
- Type, location, frequency, quality, severity of pain
- Impact on function, sleep & mood
- Autonomic dysreflexia / ↑ spasticity with SCI
- Analgesia effect

Client Specific Risk Factors
- Medical conditions / medications
- Impaired oxygenation
- Smoking status / substance use
- Advanced age
- Immuno-compromised condition
- Poor nutrition & fluid balance
- Decreased mobility & activity tolerance
- Antimicrobial resistant organisms (AROs)

Determine Mechanism of Injury & Cause of Wound
examples:
- Heels on the bed -> pressure injury
- HOB ↑ > 30° -> sacral coccyx pressure injury
- Incontinence -> IAD
- Inappropriate diabetic foot-\wear -> Diabetic Foot Ulcer
- Lower leg edema -> Venous Insufficiency

Lower Limb & Foot
- Perfusion status: peripheral pulses, capillary refill, APBI
- Skin appearance, colour & temperature differences between toes, feet & lower legs
- Presence of edema
- Protective sensation
- Weeping dermatitis / cellulitis

Wound Assessment
- Hx. current & previous wounds
- Wound location
- Measurements: length, width, depth, undermining, sinus/tunnel
- Wound bed: % of tissue type, foreign body, probes to bone etc.
- Exudate characteristics & amount
- Presence of odour
- Wound edges – opened/rolled
- Periwound skin

Infection Wound
- New onset or ↑ pain
- Odour after cleansing
- Friable granulation tissue
- Deterioration; ↑ size
- Indurated / erythema ≥ 2cm
- ↑ in or purulent exudate
- Malaise & fever

Infection Bone
- Probes to bone (query osteomyelitis

Determine Wound Etiology:
- Diabetic Neuropathic Ulcer
- Lower Limb Ulcer – Arterial, Venous or Mixed
- Pressure Injury
- Surgical Wound
- Skin Tear
- Moisture Associated Skin Damage
- Malignant Wound
- Radiation Skin Damage

Determine Wound Healability:
Based on overall wound assessment, blood circulation, underlying cause(s), client's health history / medical status, wound size, length of time wound has been open, and presence of factors that impact wound healing.

Classify the Wound Healability
- **To Heal a Healing Wound** – Healing occurs according to a predictable trajectory for the specific wound etiology in the presence of good arterial blood flow, the ability to treat the underlying cause & risk factors and participation of the client and/or family.
- **To Maintain a Non-healing Wound** – Has potential to heal, but client, wound and/or system factors are barriers, result is stalled healing.
- **To Monitor / Manage a Non-healable Wound** – Unable to heal due malignancy, risk factors/ poor arterial flow or impending death

Interventions

Client Overall Care Plan

Address Client Concerns
- Goal of care reflects client abilities, concerns, & treatment preferences.
- Refer for financial, psychosocial, mental health & chronic health issues.

Manage Pain
- Assess pain before, during and after wound care; with ↑ pain consider infection.
- Offer regular and PRN analgesics.
- Use room temperature cleansing solutions.
- Avoid over packing/filling of sinus/ tunnels.
- Reposition / consider support surfaces
- Assess / reassess pain & refer to NP/Physician if not controlled.

Manage Client Risk Factors for Wound Healability
- Medication adherence & chronic disease management
- Smoking cessation / Harm reduction substance use
- Address dietary concerns
- Mobilization (OT/PT)

General Skin Care
Refer to etiology-specific guidelines for skin care

Address Mechanism of Injury & Causative Factors: examples
- Provide pressure re-distribution
- Reduce friction/ Shear
- Manage source of moisture (urine, fecal, saliva)
- Ensure appropriate footwear
- Ensure compression stockings/garments

Provide Client Education & Resources
- Client/family re: pressure redistribution; routine surveillance of bony prominences
- Strategies to reduce friction, shear, moisture
- Recognize risk factors & when and to whom to report issues.

Wound Treatment Plan

For Moist Wound Healing
- Cleanse the wound
- Debride necrotic slough as quickly as possible using Autolytic, Enzymatic, Mechanical, Biological(Maggots) or CSWD methods
- Consult Surgeon re: treatment plan for foreign bodies (tendon, bone, suture mesh hardware)
- Treat S&S of wound infection
- Manage moisture balance
- Pack/fill (gently) dead space
- Ensure an open wound edge
- Protect the periwound skin
- Manage the closed wound

For Dry, Stable Eschar - Lower Limb/Foot
- **D**o not cleanse the eschar
- **D**o not tub bath or soak area
- **P**rotect from water during showering
- **P**aint the eschar/ 2.5cm peri-eschar area with Povidone Iodine
- **P**rotect unpainted surrounding skin
- **L**eave open to the air, or apply a dry breathable protective dressing
- **D**o not use gel, foam, trans-parent dressing, hydrocolloid or any moisture retentive dressing.
- **Monitor/** treat S&S of infection
- **R**efer to Physician/NP/Wound Clinician

Wound Infection
- Hand hygiene
- Monitor for infection (↑ pain)
- Use antimicrobial dressing
- Refer to Physician /NP for infection & if wound probes to bone

Protect the Closed Wound
- Gentle hygiene management; moisturize closed skin.
- Do not position on closed area; inspect closed area for new breakdown. Prevent reoccurrence
- Monitor & treat underlying etiology, e.g., venous insufficiency / diabetes.

Client Outcomes
- Intended outcomes met
- Intended outcomes not met