



SECTION 9: WOUND CARE

9.1 Assessment

9.1.1 Wound Assessment, Dressing Selection and Cleansing Solutions

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Aim

Optimum wound healing through accurate assessment and management.

Key Point

- Referral to CNC Stomal Therapy and Wound Management should be made for patients with large and/or complex wounds.

1. Wound Assessment

General considerations

This document is intended to provide direction for those caring for a patient with a wound. As all patients are individuals, the final decision related to wound management must be based on clinical judgment and current evidence.

Objective data related to wound assessment is the most accurate method of determining the progress of wound healing. The [wound assessment and management tool](#) (WAMT) is used to document this data and the description of wound dressing to be used.

Frequency of assessment

- Wound assessments should be made at each dressing change but a review need only be documented as per the WAMT every 48hrs or if a marked change is noted in the wound appearance.
- For complex wounds that require tracing or complicated measurements, it may be more appropriate to do a full assessment weekly.

Measuring a wound

- Measurement of the wound dimensions in mm provides a baseline to compare any changes in wound size. Wound dimensions must detail width and breadth.
- If a sinus or cavity is present depth must also be measured, using a *Visitrak™ Depth* indicator (single use item) or a disposable measuring ruler and a sterile cotton bud.
- The date and time of measurement must be documented.



Tracing a Wound

For larger irregular wounds a tracing may be made onto a sterile clear grid. If required this can be attached to a measuring device known as Visitrak™ available from the Burns Unit.



With written consent, a photograph may be taken by medical illustrations to illustrate progress.

A Visitrak device

Documentation

- With the exception of those wounds which are healing by primary intention with minimal inflammation, all wound assessments should be recorded on the [wound assessment and management tool](#) and also in the patient's record.
- A separate tool is required for each wound.
- Documentation of the wound should include:
 - Location
 - Presentation
 - Exudate type
 - Exudate amount
 - Appearance
 - Wound dimensions
 - Colour
 - Condition of surrounding skin
 - Presence of odour
 - Whether swab sent for MC&S
 - Pain score
 - Analgesia given
 - Dressing used
 - Overall assessment
 - Next review date
 - Signature
- The progress of wound healing must be documented in the patient medical record summarising the assessment findings, nursing interventions and outcomes.
- The status of the wound is to be included in the clinical handover.

2. Dressing selection:

Based on the wound assessment, select the [appropriate dressing](#) to meet the goal of care.

Choose a dressing that will:

- Promote a moist wound environment unless the clinical goal is to maintain eschar in a dry and non-infected condition.
- Maintain a constant wound temperature consistent with optimal healing (37.5°C) by minimising exposure to the air.²
- Remove excess exudate as this can cause maceration of surrounding healthy tissue and lead to further tissue breakdown.^{1,3,4}
- Provide a barrier to pathogens. ‘Strike through’ of exudate through a secondary dressing provides a direct pathway for pathogens to the wound bed.⁴
- Remove dead tissue – some dressings assist in the autolytic debridement of dead tissue.^{1,3,4}

3. Cleansing Solutions

Key Principles:

- Removing debris, exudate or foreign material from the wound allows for visualisation and thorough assessment of the wound and facilitates healing.^{1,2}
- Clean, healing wounds do not require further cleansing, as damage will occur to the healing cells.⁶
- Normal daily hygiene is recommended. Evidence suggests this does not impact on infection and/or healing rates of post operative wounds but care must be taken for chronic wounds.⁵
- It is advisable to wait 48 hours post surgery before showering/bathing.⁷
- Sterile 0.9% saline is the cleansing fluid of choice.⁸⁻¹⁰

Name	Clinical Applications	Additional Information
Sodium chloride 0.9%	Irrigation/cleaning.	<ul style="list-style-type: none"> • Should be gently warmed before use.¹⁻⁴ • Recommended for most wounds as isotonic, non toxic and is compatible with human tissue. • Has no antiseptic property.¹¹ • Causes no damage to new tissue and does not affect the functions of fibroblast and keratinocytes in healing wounds.¹⁴

Name	Clinical Investigations	Additional Information
Sodium chloride 0.9%		<ul style="list-style-type: none"> • Caution with extensive wounds where systematic absorption may occur, especially when severe renal or cardiac dysfunction is present
Povidone iodine 10% Eg. Betadine®	Topical antiseptic effective against spores, fungi, protozoa, viruses and bacteria ¹¹	<ul style="list-style-type: none"> • Inactivated by body fluids ³ especially pus or exudate so remove from wound first • Effective in reducing the bacterial load of wounds 10 minutes after application, however the effect does not persist ¹³
Chlorhexidine 0.05%	<ul style="list-style-type: none"> • Topical antiseptic and disinfectant effective against gram positive and gram negative bacteria ¹¹ • Useful in disinfecting intact skin and cleaning dirty wounds • Not for use on clean healing wounds 	<ul style="list-style-type: none"> • Must not come into contact with the meninges or mucous membrane as can cause permanent damage ^{11,14} • Antimicrobial efficacy is not fully effective as certain microbes eg. pseudomonas aeruginosa can grow with in the solution ^{11,14} • Skin sensitivity might occur ¹¹

Related policies, procedures and guidelines.

[Wound Assessment and Management Tool](#)

[Guide to choosing an Appropriate Dressing.](#)

[Pressure Injury Prevention and Management](#)

Resources.

[Visitrak™ Device Instructions for Use.](#)


[Wounds West](#) – Department of Health. Includes on-line learning module for healthcare professionals.

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