<table>
<thead>
<tr>
<th>NAME OF DOCUMENT</th>
<th>Wound – Wound Assessment and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF DOCUMENT</td>
<td>Procedure</td>
</tr>
<tr>
<td>DOCUMENT NUMBER</td>
<td>SESLHDPR/297</td>
</tr>
<tr>
<td>DATE OF PUBLICATION</td>
<td>April 2014</td>
</tr>
<tr>
<td>RISK RATING</td>
<td>Medium</td>
</tr>
<tr>
<td>LEVEL OF EVIDENCE</td>
<td>N/A</td>
</tr>
<tr>
<td>REVIEW DATE</td>
<td>April 2014</td>
</tr>
<tr>
<td>FORMER REFERENCE(S)</td>
<td>SESLHNPD/133</td>
</tr>
<tr>
<td>EXECUTIVE SPONSOR or</td>
<td>Dr Greg Keogh</td>
</tr>
<tr>
<td>EXECUTIVE CLINICAL SPONSOR</td>
<td>Stream Director</td>
</tr>
<tr>
<td></td>
<td>Surgery, Anaesthetics and Perioperative</td>
</tr>
<tr>
<td></td>
<td>Services</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Gregory.keogh@sesiahs.health.nsw.gov.au">Gregory.keogh@sesiahs.health.nsw.gov.au</a></td>
</tr>
<tr>
<td>AUTHOR</td>
<td>SESLD and ISLHD Wound Care Committee</td>
</tr>
<tr>
<td>POSITION RESPONSIBLE FOR</td>
<td>Sheila McCulloch</td>
</tr>
<tr>
<td>THE DOCUMENT</td>
<td>Clinical Stream Manager</td>
</tr>
<tr>
<td></td>
<td>Surgery, Anaesthetics and perioperative</td>
</tr>
<tr>
<td></td>
<td>Services</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Sheila.mcculloch@sesiahs.health.nsw.gov.au">Sheila.mcculloch@sesiahs.health.nsw.gov.au</a></td>
</tr>
<tr>
<td>KEY TERMS</td>
<td>Wound, Assessment, Acute wounds, Chronic</td>
</tr>
<tr>
<td></td>
<td>wounds,</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>The purpose of this procedure is to inform all clinical staff involved in wound management of wound management practices to promote wound healing and / or in the case of palliative wound management, provide comfort and minimise wound complications.</td>
</tr>
</tbody>
</table>
1. PROCEDURE STATEMENT

This procedure is to inform all clinical staff involved in wound management of practices to promote wound healing and / or in the case of chronic or palliative wound management, provide comfort and minimise wound complications.

This is achieved by holistic assessment of the patient and their wound. Wound re-evaluation is ongoing, and facilitates clinical decision-making; intervention and education which will minimise complications, aid optimal wound healing and promote patient comfort. This plan will be kept within the patient’s health care record.

2. BACKGROUND

Wound Assessment is to provide individualised wound management that is based on a holistic assessment of the patient and their wound.

Management should be prompt, appropriate, and use available resources to promote an ideal environment for wound healing/comfort.

3. DEFINITIONS (numbers relate to 8.1 – external references)

<table>
<thead>
<tr>
<th>Wound Management refers to:</th>
<th>Assessment of patient and their wound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned intervention</td>
</tr>
<tr>
<td></td>
<td>Regular re-evaluation</td>
</tr>
<tr>
<td></td>
<td>Education of Patient / carer [4]</td>
</tr>
</tbody>
</table>

| Acute Wound                 | An acute wound is any surgical wound that heals by primary intention or any traumatic or surgical wound that heals by secondary intention, and which progresses through the healing process (reaction, regeneration and remodelling phases) in an orderly and timely manner that results in sustained restoration of anatomical integrity. [1] |

<table>
<thead>
<tr>
<th>Chronic Wound / Non Healing wound</th>
<th>A chronic wound occurs when the healing process does not progress through an orderly and timely process as anticipated and healing is complicated and delayed by factors that impact on the person, the wound or the environment. [1] Also called non healing wound</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Palliative wound</th>
<th>A Palliative wound does not have the potential to heal eg cancerous wounds</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Healed Wound</th>
<th>A completely healed wound is one that has totally epithelialised and has stayed healed for a minimum of 28 days [3]</th>
</tr>
</thead>
</table>

| Palliative wound                  | Palliative wound management eg Cancerous wounds -If healing is not the expected outcome the focus of |
### Assessment

<table>
<thead>
<tr>
<th>Type</th>
<th>Acute</th>
<th>Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accurate and regular, review including assessment of wound area at least weekly</td>
<td>Accurate and regular, review including assessment of wound area at least monthly</td>
</tr>
</tbody>
</table>

### Evaluation

<table>
<thead>
<tr>
<th>Type</th>
<th>Acute</th>
<th>Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evaluation of treatment, management and intervention, at least weekly</td>
<td>Evaluation of treatment, management and intervention, at least monthly</td>
</tr>
</tbody>
</table>

### Education – patient/carer

- Education should be timely and continuous throughout the healing process and should include a maintenance plan. The information should be both verbal and written where necessary.
- Contact details for appropriate Health Care Professionals are to be made available for the patient/client.

### Health Care Record

- Documented account of a patient's/client's health, illness and treatment during each visit or stay at a hospital, nursing home, community health centre or other health care facility/service. The health care record may be in hard copy or electronic format, on approved Area forms or systems. Also known as patient medical records, it includes all documentation related to the individual patient/client, in any of the Area's health care settings.
- E.g. Patient Care Plan, Clinical Pathways, Progress Notes, EMR and CHIME; or various charts, e.g. Neurological, wound maps.

### Patient

- Any person to whom a health service provider owes a duty of care in respect of the provision of health services.

### 4. RESPONSIBILITIES

SESLHD Director Nursing and Midwifery Services, SESLHD Clinical Stream Director, Directors of Operations, Clinical Stream Directors and all clinical staff involved in wound management.
4.1 All clinical staff who attend wound management are: responsible at all times for the assessment of the wound, development of appropriate wound management plan, completion of the wound assessment chart and ongoing re-evaluation of wound management plan (in collaboration with the medical team). When nursing staff are involved a Registered Nurse (RN) is primarily responsible to ensure this happens.

An Enrolled Nurse (EN) or Trainee Enrolled Nurse (TEN) may be delegated specific wound management activities under the direct supervision of the RN.

4.2 Line Managers will: ensure all clinical staff are given the opportunity to attend District wound management education and that all nursing staff work within this procedure and have appropriate resource and stock items to implement the recommendations within this procedure.

5. PROCEDURE

5.1 Assessment

- The wound assessment and management process will involve the establishment of a management plan outlining the initial wound assessment, management plan and ongoing re-evaluation. This plan will be kept within the patient’s health care record.

- Complete a comprehensive medical history from the client to identify any underlying medical problems that may impede the healing process. If aetiology of the wound has not been defined, immediate steps must be taken to have this investigated.

- A comprehensive wound history must be obtained and documented.

- An assessment of the wound will be made using the area Wound Assessment and Management Plan (Appendix A) or Electronic Wound Templates prior to dressings being applied to a wound.

- The wound area will be used in monitoring the progress healing / or the deterioration of the wound. The wound area should be measured by manually tracing the total wound surface area or using digital wound photography and specialised computer based digital software packages.

- Refer to SESLHD Procedure ‘Wound - Clinical digital photography’ SESLHDPR/285.

  **Note:** Digital wound photography is not a standalone wound assessment tool and must be used in conjunction with assessment of the wound area.

- Address any immediate wound concerns identified e.g. uncontrolled excessive bleeding of wounds.
- Re-evaluation of the wound/s will occur weekly of an acute wound, monthly for a chronic or palliative wound. This re-evaluation process must be documented to provide evidence of wound healing or deterioration. Individualised Assessment and Management plans will be reflective of the assessments and must include all aspects of the wound care needs.

- Appropriate referrals should be made within the multidisciplinary team. As optimal healing is promoted by collaboration between all clinical staff involved in wound management.

- Involve the patients and/or their carer, (with patient’s permission) with the patient assessment.

- Provide patients and/or their carer with information on the wound assessment outcomes including wound type and treatment / potential care options.

- Provide patients and/or their carer with opportunities to and facilitate participation in planned wound care.

- Assessment of the wound, the patient / client and their healing environment will dictate the appropriate and cost effective use of wound management products and devices.

### 5.2 Management and evaluation

- Every endeavour must be made to identify factors affecting the healing process. These must be addressed where possible. All clinicians must monitor the wound for symptoms of infection and failure of the wound to respond to appropriate topical treatment. If a wound is noted to be non-healing or infected the clinician must ensure the appropriate action is taken and referrals made.

- Any bleeding wound is to be managed with a haemostatic dressing product.

- Escalate uncontrolled excessive bleeding wounds to MO or CNC wound care for immediate review.

- Wound management dressings, pharmaceuticals and devices are to be used in accordance with the manufacturer’s instructions or research protocols [5].

- Wound management is practiced in accordance with the best available evidence for optimizing healing in acute and chronic wounds.

- Patient’s choice not to follow treatment plan must be recorded in the patient health care record indicating the reason for their decision.

- To reduce and eliminate the risk of non concordance to treatment, the clinician should discuss and explain the strategies employed in wound care to the patient /client and...
carer (if appropriate). This is to assist their understanding of the treatment involved. Advise them to be alert to signs and symptoms of any contrary reactions / discomfort to treatment or when to ask for additional assistance.

- Patients / carers should be provided with appropriate handouts to reinforce teaching/learning. Where possible, translations should be provided for non-English speaking patients/carers.

5.3 Training and Education

To ensure evidence based knowledge and consistency of practice, all clinical staff involved in wound care must attend Wound Care Management education within SESLHN annually.

6. DOCUMENTATION

- Wound assessment and management plan (form number S0056)
- Any additional comments are to be recorded in the patient’s / clients health care record.
- CHIME wound care templates / clinical pathways
  - Transfer documentation e.g. from community to hospital or vice versa
  - Discharge letters should include wound assessment and management plan information

7. AUDIT

Yearly audit of wound assessment forms to ensure compliance to procedure

8. REFERENCES

8.1 External References
- NSW Ministry of Health ‘Infection Control Policy’ PD2007_036
- Department of Health NSW Patient Matters, Section 9.

8.2 Internal References

Please refer to the Surgery, Perioperative and Anaesthetics Functional Group within the Directorate of District Policies, Procedures and Guidelines

- Wound - Antiseptic dressing policy (SESLHDPR/146)
- Wound - Digital wound photography procedure (SESLHDPR/285)
- Wound - Managing pain at dressing change (SESLHDPD/275)
Wound - Compression policy (PD021)
Wound - Negative Pressure Wound Therapy policy (SESLHDPD/136)

Please also refer to the Infection Control Functional Group in the Directorate of District Policies, Procedures and Guidelines for relevant Infection Control resources

STAFF SHOULD ALSO REFER TO SITE INFECTION CONTROL MANUALS

9. REVISION AND APPROVAL HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2014</td>
<td>3</td>
<td>SESLHNPD/133 Reviewed by SESLD and ISLHD Wound Care Committee. Converted to SESLHDPR/297.</td>
</tr>
<tr>
<td>Apr 2014</td>
<td>3</td>
<td>Approved: Surgical Stream Manager and Director</td>
</tr>
<tr>
<td>Apr 2014</td>
<td>3</td>
<td>Re-formatted by District Policy Officer.</td>
</tr>
</tbody>
</table>
Appendix A: How to fill in WOUND ASSESSMENT and MANAGEMENT PLAN

Wound assessment is a continuous process and all clinicians involved in wound care need to be able to assess wounds

Complete a separate chart for each wound unless there are multiple wounds that are the same type, in the same location and having the same treatment then one chart can be used.

The Wound Assessment and Management Plan is filled in each time the dressing is attended. A full assessment on a new chart is conducted at least weekly for an acute wound or at least monthly for a chronic wound. Refer to “Wound - Assessment and Management” SESLHDPR/297.

PAGE 1 - Assessment

Complete all of page one as appropriate. Indicate by placing a tick or cross in the box or boxes that best answer the question. If the chart does not meet your needs add free text as needed

- **Question one**: Objective of wound management:
  Explanation: What are you trying to achieve? It is not always healing eg in palliative wounds it may be comfort.

- **Question two**: Wound location:
  Explanation: Anatomical drawings are here to mark where the wound is and there is also a place to write in your own words the wound location.

- **Question three**: Wound Type/Aetiology:
  Explanation: This is important as it directs wound care (eg care of a venous leg ulcer is very different to care of an arterial ulcer).
  In question three indicate by circling the type of wound when there are multiple answers e.g. surgical/breakdown it could be an expected surgical wound therefore cross out breakdown or circle breakdown if it is surgical wound breakdown (required for coding of medical record).

- **Question four**: What does the wound bed look like (eg if the wound bed is sloughy a dressing needs to be used that will debride the slough) – once slough debridement is achieved the wound needs to be reassessed for an appropriate dressing.

- **Question five**: Infection impacts on wound healing.

- **Question six**: Wounds are sometimes bigger than the opening indicates so need to be explored to make sure there is no undermining and if there is, it is included in the dressing. The direction of tunnel or sinus is marked on the clock face with the person’s head always being the 12o’clock direction, the feet are the 6o’clock direction and the person’s side being the 3 or 9 o’clock direction.
  - To measure the depth of a wound use a sterile probe
  - The length of the wound is always head to toe and the width is always across the body

- **Question seven**: Odour impacts on the patient carers and nurses: There are dressings and topical products that can be used for malodour. Perfumed sprays and oils are also useful eg policy antiseptic wound policy
Question eight: Pain impacts on wound healing so needs to be managed appropriately eg policy "Managing Pain at Dressing Change".

Question nine: It is important that the skin around the wound is not damaged as this will cause the patient more pain. Consider such things as barrier wipes to protect skin.

Question ten and ten (a): the answer is either a wound or a pressure injury.

Question ten: Wound measurement is part of the assessment procedure. It can also have an impact on the choice of dressing.

Question ten (a): Describe the pressure injury (PI) eg what stage is the PI?

Question eleven: Exudate needs to be managed appropriately eg dressing should be used that will manage the estimated amount of exudate. Consider bag or NPWT if exudate more than 100 mls in 24 hours.

Sign and date page

PAGE 4- Wound size

Complete wound area page 4 "by tracing the wound" using grids, 2 layers of cling wrap or any 2 layers of clear, clean and flexible product e.g. back of dressing packs, back of combine packets. Include areas of necrotic tissue slough and areas of callous surrounding the wound.

Tick box if photo taken

Sign and date page

If the patient requires referral to another health professional record, this on the bottom of page 4 and can be done at any time the form is active

PAGE 2- Management plan - There are three sections on page 2. All of the assessment criteria are considered when writing the management plan.

Section one is filled in for standard wound management after discussing wound care with patient / carer and giving education on wound management.

When recording the length of a wound it is head to feet and width is always across the body

If the person who wrote the dressing plan attends the dressing, indicate dressing attended.

If another health professional attends the dressing they need to fill in column one page three

At all times the patient needs to be involved in their plan and education must be given.

Sign and date section
**Section two** is filled in as a review process if wound management in section one fails to meet wound needs- as documented on page 3 - Sign and date session

If the person who wrote the dressing plan attends the dressing, indicate dressing attended.

If another health professional attends the dressing they need to fill in a column on page three

**Section three** is only filled in for patients receiving Negative Pressure Wound Therapy (NPWT). Section one and two are not required –
There are several different NPWT and various different configurations of fillers (eg foam and gauze) – it is important this section is completed so that there is continuity of wound care.

- Brand: which brand is used and type
- Setting: what is the machine set to run at
- Care of the surrounding skin: what has been used to protect the skin. Examples of skin protection: barrier film, film dressing, hydrocolloid, silicone tape. Wound products are used if the port is too large for the wound and there is a need to support the port and protect the skin eg hydrocolloid, if such a wound product is used it may absorb wound exudate. This may lead to peri-wound maceration if the product can’t control the exudate or set the wound product slightly back from the wound edge. Fragile skin may be damaged if a film is put directly onto it consider silicone tape or silicone film.
- Packing product chosen needs to conform to the wound bed and not damage underlying tissue
- “Other” is for wound fillers not listed eg PICO foam
- Size what size dressing was needed
- The frequency of dressing is based on the type of filler chosen and when the dressing is going to be changed eg NPWT dressing changed in theatres may be left longer that a dressing changed on the ward or persons home.
- Sign and date section
- Include wound management directions for patient on disposal NPWT in section three

**Documentation of initial wound assessment and management plan is complete once pages 1, 2 and 4 are finished.**

**PAGE 3 – Subsequent dressing changes**

- Each wound dressing intervention must be recorded on page 3 (except if the initial dressing is attended by the person who wrote the wound plan at the same time the plan was written, as per instructions on how to fill in page 2 above)
- The first column on page three should be used to record dressing intervention
  - If the management plan does not meet the objective of the wound care;
    - a) a second management plan can be instigated by completing section 2 on page 2
    - b) consider referral to MO or wound CNC or CNS2 record this on bottom of page 3
- Sign and date column
- Further documentation in the progress notes is recorded as wound care attended as per wound care chart, Note you can only write this if you have recorded and signed your name on the wound care chart.