

SESLHD PROCEDURE COVER SHEET



Health
South Eastern Sydney
Local Health District

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Nursing and Midwifery Services
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FUNCTIONAL GROUP(S)	Infection Control Critical Care and Emergency Medicine Nursing and Midwifery
KEY TERMS	Wound, Assessment, Acute wounds, Chronic wounds, documentation
SUMMARY	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.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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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.

After completing the assessment of the patient and their wound, staff must explain to the patient and their caregiver the plan of care for their wound/s and discuss with the treating team.

Once the treatment plan is agreed and before commencing the wound treatment plan patient/caregiver must give valid consent as per the NSW Health Consent to medical and Healthcare Treatment Manual.

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.

Definitions

Wound Management refers to:	Assessment of patient and their wound Planned intervention Regular re-evaluation Education of Patient/caregiver ¹
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 remodeling phases) in an orderly and timely manner that results in sustained restoration of anatomical integrity ¹
Chronic Wound/Non Healing wound	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.
Palliative wound	A Palliative wound does not have the potential to heal e.g. cancerous wounds
Healed Wound	A completely healed wound is one that has totally epithelialised and has stayed healed for a minimum of 28 days ³

Palliative wound management	Palliative wound management - If healing is not the expected outcome the focus of management is on aesthetics, comfort, prevention of bleeding and dealing with malodor (usually caused by infection) ¹	
Assessment	Acute	Accurate and regular, review including assessment of wound area at least weekly
	Chronic and palliative	Accurate and regular, review including assessment of wound area at least monthly
Evaluation	Acute	Evaluation of treatment, management and intervention, at least weekly
	Chronic	Evaluation of treatment, management and intervention, at least monthly
	Palliative	Evaluation of symptom control, at least monthly
Education – patient /caregiver	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	<p>Documented account of a patient’s health, illness and treatment during each visit or stay at a hospital, nursing home, community health centre or other health care facility/service². 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 in any of the Area’s health care settings.</p> <p>E.g. Patient Care Plan, Clinical Pathways, Progress Notes, SESLHD Wound Assessment and Management Plan SES060.118, eMR or various charts, e.g. Neurological, wound maps, Wound Assessment Treatment Evaluation Plan (WATEP), IView- wound care</p>	
Patient	Any person to whom a health service provider owes a duty of care in respect of the provision of health services ² Note various health services may also refer to this person using another terminology e.g. client is used in community health.	

3. RESPONSIBILITIES

3.1 Nursing staff will:

- Adhere to the content of this document
- Work within their scope of practice
- Attend relevant education related to this procedure.

3.2 Line Managers will:

- Facilitate clinical staff awareness of this document
- Provide support to staff to adhere to the content of this document
- Have the resources to implement this procedure.

4. PROCEDURE

4.1 Assessment

- 4.1.1 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 electronic medical record (eMR).
- 4.1.2 Complete a comprehensive medical history from the patient 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/diagnosed.
- 4.1.3 A comprehensive wound history must be obtained and documented
- 4.1.4 An assessment and reassessments of the wound/s will be made using the SESLHD Wound Assessment and Management Plan (Appendix A) or Electronic or the electronic equivalent prior Wound Templates prior to dressings being applied to a wound. Note: stage one pressure injuries and eschar wound/s are to be documented on the ISLHD Wound Assessment and Management Plan (Appendix A) or the electronic equivalent prior Electronic Wound Template.
- 4.1.5 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 procedure SESLHDPR/285 - [Wound - Clinical Digital Photography](#). Note Digital wound photography is not a standalone wound assessment tool and must be used in conjunction with written assessment of the wound area.
- 4.1.6 Address any immediate wound concerns identified e.g. uncontrolled excessive bleeding from a wound
- 4.1.7 Any eschar wound (necrotic tissue covering deep unhealed tissue) must be monitored daily for infection/stability whilst an inpatient and on each dressing change in the outpatient community setting.
- 4.1.8 Documented assessment and review of a wound must occur in the clinical notes at least weekly with formal documentation within WATEP/Wound Care Charts on a weekly basis for acute wounds and monthly for chronic/palliative wounds or if there is a change in the wound i.e. improvement or deterioration. This assessment 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.
- 4.1.9 Appropriate referrals should be made within the multidisciplinary team as required. As optimal healing is promoted by collaboration between all clinical staff involved in wound management.
- 4.1.10 A thorough assessment involving the patient and/or their caregiver is essential to establish goals and outcome measures for the patient and their wound.

- 4.1.11 Provide patients and/or their caregiver/with information on the wound assessment outcomes including wound type and treatment/potential care options.
- 4.1.12 Provide patients and/or their caregiver with opportunities to and facilitate participation in planned wound care.
- 4.1.13 Assessment of the wound, the patient (their point of view) and their healing environment will dictate the appropriate and cost-effective use of wound management products and devices.

4.2 Management and evaluation

- 4.2.1 Every effort endeavor 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.
- 4.2.2 Any wound that is bleeding should be managed with a dressing that has haemostatic properties for example: a calcium alginate dressing.
- 4.2.3 Escalate uncontrolled excessive bleeding wounds to MO or CNC wound care for immediate review and investigation as to cause of bleeding.
- 4.2.4 Eschar wound - If any signs of infection or unstable eschar noted, MO/GP should be informed for review. Note unstable eschar is necrotic tissue that becomes wet, draining, loose, boggy, oedematous, or has spreading redness from the wound edge.
- 4.2.5 Wound management dressings, pharmaceuticals and devices are to be used in accordance with the manufacturer's instructions or research protocols⁴.
- 4.2.6 The number of pieces of wound filler used needs to be recorded on the outside of the dressing at each dressing change and in the health care records e.g. on Wound Assessment and Management Plan
- 4.2.7 The number of pieces of wound filler removed from the wound needs to be recorded at each dressing change in the health care records e.g. on Wound Assessment and Management Plan.
- 4.2.8 Wound management is practiced in accordance with the best available evidence for optimising healing in acute and chronic wounds.
- 4.2.9 Patient's choice not to follow treatment plan must be recorded in the patient's eMR indicating the reason for their decision.
- 4.2.10 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 and caregiver (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.
- 4.2.11 Patients/caregivers should be provided with appropriate handouts to reinforce teaching/learning. Where possible, translations should be provided for non-English speaking patients/caregiver.

4.3 Training and Education

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

5. DOCUMENTATION

Wound Assessment & Management Plan Form SEI060.118 (form number S0056) or the electronic equivalent e.g. Wound Assessment Treatment Evaluation Plan (WATEP) or iView wound care form.

Any additional comments are to be recorded in the patient's Health Care Record eg eMR. Transfer documentation e.g. from community to hospital or vice versa. Discharge letters should include wound assessment and management plan information.

6. AUDIT

Yearly audit of wound assessment forms to ensure compliance to procedure.

7. REFERENCES

7.1 External References:

1. Carville K. 2023, Wound Care Manual 8th edition, Silver Chain Foundation, Perth
2. Department of Health NSW Patient Matters, Section 9.
3. Linbald W.J. 2001, FDA Wound Repair Regan Vol. 9 (4): 257
4. Wounds Australia Inc., 2016 Standards for Wound Prevention and Management. 3rd edition

7.2 Internal References

LHD Procedures:

<https://www.seslhd.health.nsw.gov.au/policies-and-publications/functional-group/90>

[SESLHDPR/146 - Wound - Antiseptic Dressing Policy](#)

[SESLHDPR/285 - Wound - Clinical Digital Photography](#)

[SESLHDPR/437 - Wound - Managing Pain at Dressing Change](#)

[SESLHDPR/398 - Wound - Graduated Compression Therapy \(GCT\) in Venous Disease](#)

[SESLHDPD/136 - Wound - Negative Pressure Wound Therapy \(NPWT\)](#)

Please also refer to applicable Infection Control resource:

[NSW Health Policy Directive PD2023_025 - Infection Prevention and Control in Healthcare Settings](#)

SESLHD Infection Control Policies, Procedures and Guidelines

Internet: Functional Group

[Home >> SESLHD Policies Procedures and Guidelines >> Infection Control](#)

STAFF SHOULD ALSO REFER TO SITE INFECTION CONTROL MANUALS

Clinical Incident

[NSW Health Policy Directive PD2020_047 - Incident Management Policy](#)

Consent to Medical and Healthcare Treatment Manual

<https://www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx>

8. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
May - July 2006	Draft	Wound Care Co-ordinators, Debbie Blanchfield, Southern Sector, Ann Stewart, Central Sector and Carol Stott, Northern Sector.
August 2006	0	As above, approved for release by the Area Executive Committee, 15 August 2006
May 2011	1	Combined SESLHN and ISLHN wound care committees (Chairperson Debbie Blanchfield)
July 2011	0	Approved by SESLHD Clinical and Quality Council
August 2011	2	Links in Area Infection Control manual updated - Acting Policy Officer Michelle Bonner
January 2014	3	SESLD and ISLHD Wound Care Committee
April 2014	3	Approved: Surgical Stream Manager and Director
4.5.2015	Revision 1 draft 2	Combined SESLHD and ISLHD wound care committees (Chairperson Carol Stott)
15.7.2018	Revision 2 V1	Combined SESLHD and ISLHD wound care committees (Chairperson Kay Maddison)
August 2018	Revision 2 V1	Minor review endorsed by Executive Sponsor
September 2018	Revision 2 V1	Processed by Executive services prior to publication
November 2021	4	Review commenced by SESLHD and ISLHD Wound Care Committee. Hyperlinks and references updated.
February 2022	4	Approved by Executive Sponsor.
18 December 2024	4.1	Minor review. Minor grammatic improvements and change to 4.1.8 to better reflect current practice and the results of the recent community wound care prevalence audit.

Appendix A: How to fill in WOUND ASSESSMENT and MANAGEMENT PLAN

Wound assessment is a continuous process, 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.

Stage one pressure injuries and eschar wound/s are to be documented on the SESLHD Wound Assessment and Management Plan or Electronic Wound templates.

Exception A wound chart does not need to be used for a primary closed wound (*intact* with sutures/clips/steri strips/skin glue) however if the area is open a wound chart must be used. Documentation of surgical primary closed wound in is the progress notes.

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 PD"

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** the objective of wound management, - explanation - what are you trying to achieve, it is not always healing e.g. 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 location of the wound
- **Question three** Wound Type/Aetiology - explanation - it is important to find this out as it directs wound care e.g. care of a venous leg ulcer is very different to care of an arterial ulcer
- Breakdown 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 or circle breakdown if it is surgical wound breakdown - this is needed for the coders
- **Question four** What does the wound bed look like e.g. if the wound bed is sloughy a dressing needs to be used that will debride the slough - once this 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 12 o'clock direction, the feet are the 6 o'clock direction and the person's side being the 3 or 9 o'clock direction.
- To measure the depth of a wound a sterile probe must be used.
- 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, caregivers and nurses - there are dressings and topical products that can be used for malodour see SESLHDPR/750 - [Wound - Antiseptic Dressing](#). Perfumed sprays and oils are also useful.
- **Question eight** Pain impacts on wound healing so needs to be managed appropriately e.g. 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 - e.g. consider such things as barrier wipes to protect skin
- **Question 10 and 10a** the answer is either a wound or a pressure injury
- **Question 10** wound measurement is part of the assessment procedure. It can also have an impact on the choice of dressing
- **Questions 10a** describe the pressure injury e.g. what stage is the PI?

- **Question 11** exudate needs to be managed appropriately e.g. dressing should be used that will manage the estimated amount of exudate. Consider bag or NPWT if exudate more than 100mls in 24 hours.
- **Sign and date page**

PAGE 4 - Wound size

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

Do not touch the wound with grid unless the tracing tool is sterile, hold directly above wound edges to trace.

- 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 2

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 /caregiver 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 configuration of fillers e.g. foam and gauze – it is important this section is completed so that there is continuity with 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 e.g. hydrocolloid. If such a wound product is used it may absorb wound exudate and this may lead to peri-wound maceration. If the product can't manage the exudate 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 e.g. PICO foam

- Size what size dressing was needed
- Frequency of dressing this is based on the type of filler chosen and when the dressing is going to be changed e.g. NPWT dressing changed in theatres may be left longer than a dressing changed on the ward or persons home. E.g. generally, gauze filler can stay in place for 4 days and foam filler for 3 days but this is dependent on the wound type and wound observation required.
- 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 ward/unit wound champion or CNE or wound care CNC 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.

Appendix B: Glossary of Wound Care Terms and Definitions

Abrasion	An injury caused by rubbing or scraping that results in the loss of the superficial layer of skin or epidermis and or dermis and may involve the mucous membrane.
Abscess	A localised collection of pus.
Acid Mantle	Body's natural protection of the outer layer of skin having a pH between 4.0 and 5.5. Made from sebum and sweat. Inhibits the growth of harmful micro-organisms and pollutants.
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.
Acute wound Assessment	Accurate and regular, review including assessment of wound area at least weekly. Or if there is a significant change in the wound.
Acute Wound Evaluation	Evaluation of treatment, management and intervention, at least weekly.
Angiogenesis	The process of forming new blood vessels. Occurs in the granulation phase of healing in wound repair.
Ankle Brachial Pressure Index	Ankle Brachial Pressure Index (ABPI) - ratio of ankle arterial systolic blood pressure to brachial pressure.
Antiseptic	See dressings Antimicrobial.
Arterial Insufficiency	Reduced arterial blood flow in the artery due to narrowing of the lumen leading to ischemia.
Arterial Perfusion	The movement of oxygenated blood through tissues to the arteries.
Arterial Ulcer	Ulcer which results from an inadequate blood supply due to arterial insufficiency. Usually located on distal extremities.
Atrophy Blanch	Smooth depressed ivory white plaques found on the lower leg in advanced venous disease. They can be mistaken for scar tissue or healed venous leg ulcers.
Autograft:	A skin graft which is taken from an individual and reapplied to the same individual.
Autolysis	The process where devitalised or dead tissue is self-digested through the action of enzymes.
Bacterial Burden or Load	The number and virulence of bacteria in a wound.
Blanching	When pressure is applied to a reddened area (inflammation) the area under the pressure becomes white and then returns to the red.
Buerger's Disease	An inflammatory, occlusive disorder of the small and medium-sized arteries and veins in the distal extremities. Most cases occur in men under the age of 40, who smoke cigarettes. AKA Thromboangiitis Obliterans.
Buerger's sign Dependent Rubor	A redness or purple colour of a leg when it is in the dependent or lowered position. If the leg blanches on elevation it may be a sign of lower leg ischemia.
Burns depth	<ul style="list-style-type: none"> • Epidermal • Superficial dermal partial thickness • Mid dermal partial thickness • Deep dermal partial thickness • Full thickness

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Cellulitis	A local soft tissue inflammatory reaction which occurs following bacterial invasion of the skin. It involves deeper dermis and subcutaneous fat and is characterised by pain or tenderness, swelling, warmth and erythema that blanches on palpation. Cellulitis can be acute, subacute or chronic and can be accompanied by pyrexia and general malaise.
Champagne Leg	See Lipodermatosclerosis.
Charcot Foot	(Char Coe) foot a progressive condition affecting the musculoskeletal system of the foot in persons with diabetes. Fractures of the bones in the foot joint dislocation and deformities can occur. The bottom of the foot has the appearance of the hull of a boat due to the arch of the foot collapsing.
Chronic wound Evaluation	Evaluation of treatment, management and intervention, at least monthly.
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.
Chronic wound Assessment	Accurate and regular, review including assessment of wound area at least monthly.
Claudication	(Intermittent) Inadequate blood supply to the muscles on the leg associated with narrowing of the arteries leading to cramping pain on exercise.
Collagen	A protein that is the principle component of skin, bone, tendon cartilage and other connective tissue. Collagen is needed in wound repair to provide the scaffolding in which the wound fills in when healing with secondary intention.
Compression (reduced, light or mild)	Graduated compression therapy which is not effective in the treatment of venous leg ulcers.
Compression Bandages High / long stretch	Provide both a high resting pressure and a high working pressure eg has elastic in its properties.
Compression Bandages Short stretch bandages	Provide a low resting pressure and a high working pressure e.g. has no or little elastic in its properties.
Compression Bandages	Can be cotton and/or synthetic, with or without elastic or latex and are described as short or high/long stretch bandages.
Compression Garments	Include manufactured graduated compression hosiery eg compression stockings.
Compression Levels	Vary against type of pressure wanting to be achieved.
Compression Therapy	Graduated compression can be achieved through compression stockings or compression bandages and includes the use of intermittent pneumatic compression pumps.
Continuous therapy:	A constant sub atmospheric pressure applied to a wound bed.
Critical colonisation	See localised infection.
Debridement	Removal of foreign material and non-viable, necrotic or senescent tissue. May be surgical, conservative sharp, mechanical, autolytic, biological or enzymatic. A wound should be clear of dead or devitalised tissue to support healing and reduce the risk of infection There are many ways to debride.
Dehiscence	The opening of a sutured wound; may be due to infection, haematoma, protein deficiency, anaemia.
Delayed primary intention	When the wound is infected or contains foreign bodies and requires intensive cleaning, prior to primary closure 3-5 days later
Dermal	Related to skin or derma.

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Dermis	The second layer of the skin, under the epidermis. This layer provides blood supply to the nonvascular epidermis, contains the sweat and sebaceous glands, hair follicles, lymph and blood vessels nerves and pigment cells.
Dermatitis	Inflammation of the skin.
Dessication	Drying out due to lack of moisture. In a wound environment, leads to tissue death.
Devitalised tissue	See Necrotic Tissue.
Dressing Antimicrobial	Antimicrobial dressings are antiseptic for killing micro-organisms or suppressing their multiplication or growth.
Dressing Antiseptic Gauze	Gauze containing polyhexamethylene biguanide (PHMB).
Dressing Calcium Alginates	A dressing manufactured from processed kelp (seaweed). Used for exudate management and haemostasis.
Dressing Films	Dressings that provide a moist wound environment and protect the wound and skin from chemicals, friction, shearing forces and microbes.
Dressing Foam	Often made of polyurethane, are soft, open-cell sheets in either single or multiple layers. They vary greatly in their ability to absorb exudate and in their permeability. They provide a moist environment, are absorbent, conformable, protective and cushioning.
Dressing Hydrocolloids	A dressing that is described as moisture retentive as the hydrophilic particles absorb moisture and convert to a gel at the wound interface.
Dressing Hydrofibre	Non-woven sodium carboxymethylcellulose spun into fibres and manufactured into sheet and ribbon packing dressing.
Dressing Hydrogels	A dressing that has water as its dispersion medium. Available as either sheets, gel or impregnated gauze.
Dressing Hypertonic saline	Salt solution having a higher osmotic pressure than physiologically normal. Indication for use on hyper-granulating wounds.
Dressing Interface	A non-adherent open weave dressing eg Atrauman, Mepitel. This is placed between the wound base and the wound filler dressing.
Dressing Island dressing	Combined primary dressing with adhesive secondary dressing.
Dressing Negative Pressure Wound Therapy	The application of controlled levels of negative pressure. This has been shown to accelerate debridement and promote healing in many different types of wounds through the removal of interstitial fluid, decreasing localised oedema, increasing blood flow and decreasing tissue bacterial levels.
Dressing non-adherent	Non-woven alternatives to gauze for use as pads or for cleaning wounds.
Dressing Occlusive	When referring to a dressing, is an air- and water-tight dressing that seals the wound from the external environment.
Dressing Paraffin gauze	Consist of a piece of woven cotton or viscose, or a combination of the two, impregnated with yellow or white soft paraffin. Paraffin gauze may adhere to the wound can cause trauma on removal and is also permeable to micro-organisms.
Dressing Primary dressing	The dressing in direct contact with the wound.
Dressing Secondary dressing	A dressing placed over the top of one that is in direct contact with the wound bed.
Dressing Semi-permeable	When pertaining to wound care dressings, it is a property where certain type of molecules are allowed to pass through a membrane while other types of

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	molecules are not. For example, oxygen molecules may be allowed to pass but bacteria are not. See Moisture Vapour Permeability (MVP).
Dressing Soft silicone	A dressing that contains a soft silicon contact layer. Provides gentle adhesive and atraumatic removal properties.
Dressing Vapour Permeable	Allows the passage of some molecules but not others ie gases and water vapour can pass through a membrane.
Dressing Zinc Paste Bandage	An open weave bandage which is impregnated with zinc. Used to soothe & protect skin from excoriating wound fluid.
Ecchymosis	Discoloration of an area of skin caused by the leakage of blood into the subcutaneous tissues as a result of trauma to the underlying blood vessels.
Education – patient and caregiver	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.
Endothelial buds	Endothelial cells provide the inner lining of blood vessels and are sent out as buds to infiltrate areas of new tissue to begin a new blood supply.
Enterocutaneous fistula	Abnormal passage between the GIT and the skin.
Enzymes	A protein secreted by cells that acts as a catalyst to induce chemical changes capable of breaking down necrotic tissue.
Epidermis	Outermost layer of the skin.
Epithelialisation	The process of epithelial cell formation and migration from the wound edges (including hair follicles) that close over the wound. Regeneration of epithelium over a wound
Erythema	Abnormal redness of the skin due to vasodilation (as in inflammation).
Eschar	Necrotic tissue that forms a black thickened covering over wounds Dry, avascular necrotic tissue, typically black or brown in colour and of tough/leathery consistency. The term “eschar” is NOT interchangeable with "scab".
Eschar stable	Stable intact (dry, adherent, intact without erythema and not moveable) eschar should not be removed.
Eschar unstable	If the eschar becomes unstable (wet, draining, loose, boggy, oedematous, red) medical review is required. A management plan should consider if the removal of the necrotic tissue is required.
Extravasation	Leakage of fluid from a blood or lymph vessel into surrounding tissue.
Exudate	Fluid that comes from wounds. Can be clear (serous), sanguineous (bloody) or purulent (pus). Liquid material composed of serum, fibrin, cellular debris and white blood cells that escapes from the tissues into a wound
Fascia	A band or sheet of connective tissue found throughout the body.
Fenestration	Perforations, window or hole.
Fibrin	A protein involved in the blood clotting process. Can also be involved in the granulation phase of healing.
Fibrin network	A protein which is leaded from the blood circulation and becomes an insoluble protein in wounds.
Fibroblast	A cell in connective tissue that secretes collagen and elastic fibres.
Fistula	An abnormal passage between two or more structures or spaces.
Flap	A piece of tissue partly severed from its place of origin for use in surgical grafting. May comprise of skin, subcutaneous tissue and deeper structures such as muscle +/- bone. A flap has a blood supply that is local or the blood

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	supply can be detached from the donor site and re-anastomosed at the recipient site, i.e. free flap.
Friable Tissue	Tissue that bleeds easily. Then this occurs in a chronic wound, infection should be suspected.
Friction Injury	Friction occurs when two surfaces move across each other. It often removes superficial layers of skin. Friction damage often occurs because of poor lifting techniques. Note Friction Injury is no longer included as a PI definition.
Full thickness skin graft	A skin graft which is excised from the body at or under the deep or reticular dermal level, the resulting donor site cannot re-epithelialise spontaneously.
Full thickness wound	Refers to depth of tissue damage that extends beyond the skin and at least into the subcutaneous tissue. May extend down to muscle, tendon and/or bone. Tissue loss involving the epidermis, dermis and subcutaneous tissue.
Fungating	Tissue that assumes a fungal form or grows quickly like a fungus.
Graft	An implant of living tissue undertaken surgically. The transfer of tissue from one part of the body to the other e.g. skin graft.
Granulation tissue	Pink to red, fragile and moist capillary tissue that fills in an open wound bed during the proliferative phase of wound healing.
Growth Factors	A substance produced by cells that stimulates them to multiply Specialised proteins that cause cells to migrate to an area as well as make other proteins needed in healing.
Haematoma	A localised collection of blood or clot of blood in the tissues, caused by injury, disease, or a clotting disorder.
Haemosiderin Staining	A discoloration of the lower leg often present in venous disease. It is caused by the release of iron containing pigment as red blood cells disintegrate. Staining can be seen above the ankle and can be an indicator of venous disease.
Healed Wound	A completely healed wound is one that has totally reepithelialised and has stayed healed for a minimum of 28 days.
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. [2]. 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.
Holistic	An approach to care that supports many relationships and disciplines to support a comprehensive treatment plan.
Homeostasis	The ability of a system such as the human body, to maintain equilibrium when changes occur.
Hyperaemia	Excess of blood in a tissue; engorgement or congestion of blood in a tissue.
Hyperbaric oxygen therapy (HBOT)	Involves breathing pure oxygen in a pressurized room or tube to increase the amount of oxygen in your blood to be carried to organs and tissues. HBOT is a treatment used to aid wound healing and treat necrotising fasciitis as well as for other conditions such as decompression sickness and serious infections.

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Hypergranulation / Over granulation	Abnormal granulation tissue that is raised above the level of the peri-wound area. The tissue is soft, spongy and friable (bleeds readily). Also known as over-granulation, exuberant granulation, granulation hypertrophy, hyperplasia of granulation.
Hyperkeratosis	The thickening of the skin such as callus formation.
Hypodermis	A layer of cells below the dermis that store fat and anchor the skin to the underlying structures. Layer of tissue situated below the dermis.
Incontinence Associated Dermatitis (IAD)	A term used to describe skin damage associated with exposure to stool or urine.
IIMS (Incident Information Management System)	A computerised system for collecting, classifying, managing, analysing and learning about all incidents that happen within LHD.
Induration	A process where the skin becomes firm, often surrounds a wound as a healing ridge or can be a sign of building bioburden. Abnormal firmness of tissue with a definite margin. An increase in the fibrous elements in tissue commonly associated with inflammation and marked by loss of elasticity and pliability.
Infection	The presence of micro-organisms that have overwhelmed the body's defences resulting in damage to the host; accompanied by local or systemic symptoms.
Inflammation / inflammatory response	A series of changes in tissue indicating their reaction to injury, whether mechanical, chemical or bacteria, so long as the injury does not cause death of the affected part. The cardinal signs are: heat, swelling, pain and redness.
Inflammatory phase of healing	The body's initial response to injury and lasts between two to 4 days. During this phase the body attempts to close off broken blood vessels and clean up the wound.
Intermittent Claudication	Often identified as a pain in the lower limbs related to poor or compromised blood supply. The pain usually occurs when walking and relieved with rest.
Intermittent pneumatic compression (IPC) systems	Intermittent pneumatic compression (IPC) is a mechanical method of delivering Sequential compression to swollen limbs.
Ischaemia	Deficiency of blood caused by functional constriction or obstruction of a blood vessel to a part a deficiency of blood supply to an area.
Itch	Is an irritating sensation inciting a scratch response and can be acute or chronic. An acute itch is usually relieved by pain or scratch and is caused by skin contact with an irritant. A chronic itch emanates from a physical condition or skin condition.
Keratotic	Any horny growth, such as a wart.
Laceration	A wound caused by a sharp object producing edges that may be jagged, dirty, or bleeding. Lacerations most often affect the skin, but any tissue may be lacerated, including subcutaneous fat, tendon, muscle, or bone.
Lanarkshire Oximetry Index (LOI)	A protocol for pulse oximetry toe/finger O ² Saturation to check the suitability of compression therapy.
Lipodermatosclerosis	Inverted shape of a leg that looks like an inverted champagne bottle can occur in advanced venous disease and is associated with fibrosis and necrosis of the subcutaneous fat. The acute phase can be misdiagnosed as cellulitis and is characterised by a localised painful area on the lower leg which is inflamed indurated and oedematous.

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Localised infection	(previously known as critical colonisation) - A wound with a level of bacterial colonisation that impairs wound healing but with an absence of host signs of clinical infection ⁵ . Other signs of localised infection include an increase or alteration in pain, periwound oedema, friable granulation tissue, malodour and wound bed discoloration, an increase or alteration in exudate, induration, pocketing and bridging.
Loss of Protective Sensation (LOPS)	Occurs in persons with diabetes where feeling in the feet is diminished or absent. This places the area at risk for developing wounds also see neuropathy.
Maceration	A softening and whitish look to the intact skin around wounds caused by excessive moisture. Often occurs when exudate is not well managed by dressings. Macerated tissue often has a white appearance and feels boggy to the touch.
Macrophage	A white blood cell that cleans up the wound, ingesting dead cells, micro-organisms, foreign material and other debris.
Malodorous	Having an unpleasant smell/bad odour.
Matrix Metalloprotease (MMP's)	An enzyme that breaks wound proteins during wound healing. When found in large numbers in chronic wounds these enzymes can interfere with healing as they will break down good proteins as well as proteins that can negatively impact healing.
Maturation Phase of Healing	The final phase of wound healing that begins at about day 21 of the healing process and can last up to 2 years. During this phase collagen is restructured and the scar tissue softens and changes colour. The closed wound is only about 80% as strong as the tissue was before injury.
Moist wound healing	Keeping a wound covered to retain a damp environment at the wound base. 1962 George D. Winter discovered that epithelisation, the process of wound closure, would proceed twice as fast in a moist environment than under a scab.
Moisture Vapour Permeability (MVP)	Water-vapour permeability is the "ability of a coated fabric to transmit water vapour above a specified level whilst maintaining a high degree of water penetration resistance".
Necrotic tissue	Dead tissue that usually presents as black or brown and is hard or leathery in texture. Also referred to as Devitalised tissue.
Negative Pressure Wound Therapy (NPWT)	See Dressing Negative Pressure Wound Therapy (NPWT).
Neuropathy	Any abnormal degenerative or inflammatory state of the peripheral nervous system. Symptoms include, numbness, tingling or pain in the extremities, also see LOPS.
Oedema	Swelling.
Offload	To reduce or eliminate pressure from an area.
Orthotic	An orthopaedic appliance such as a form placed in a shoe to support the foot or redistribute pressure areas.
Osteomyelitis	Inflammation/infection of a bone.
Oxygenation	Providing oxygen to an area or system.
Palliative wound	Wounds that do not have the capacity to heal e.g. Cancerous wounds -If healing is not the expected outcome the focus of management is on aesthetics, comfort, prevention of bleeding, infection and dealing with malodour (usually caused by infection).
Paresthesia	A non-painful abnormal sensation such as numbness tingling, burning for a feeling of skin stiffness.

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Pathogen	An organism that can cause disease such as a virus, bacteria or other micro-organism.
Patient	Any person to whom a health service provider owes a duty of care in respect of the provision of health services.
Perfusion	The pumping of a liquid into tissues or an organ. Delayed wound healing can result if there is inadequate oxygen perfusion to the wounded area.
Peri-wound	The tissue that surrounds the wound.
Phagocytosis	The process where cells surround and digest cell debris, micro-organisms, necrotic tissue and foreign bodies.
Pressure Injury	Is localized damage to the skin and /or underlying tissue, because of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful.
Pressure Injury Shear	Shearing occurs when the skeleton and deep fascia slide downwards with gravity, while the skin and upper fascia remain in the original position. Deep necrosis can occur when the shearing between two layers of tissue leads to stretching, kinking, and tearing of vessels in the subcutaneous tissue. Shearing most often occurs when individuals slide down, or are dragged up, a bed or chair.
Pressure reduction	A device or surface designed to reduce pressure over an area.
Pressure Relief	A device or surface designed to provide pressure relief over an area.
Primary intention healing	Healing with minimal granulation tissue formation and minimal scarring e.g. healing following surgical closure of a wound by suturing or stapling.
Proliferate	To increase in number.
Proliferative Phase of Healing	The second phase of healing lasting 3 to 21 days. During this phase the wound fills in with granulation tissue, contraction of the wound occurs, and epithelialisation takes place. This phase reduces the area and depth of the wound.
Purulent	Containing or forming pus.
Re-epithelialisation	The formation of new epithelial tissue (epidermis) over a wound. Usually signifies wound healing and closure.
Remodelling	The final phase of wound healing with regression of capillaries and cross linking of collagen fibres.
Revascularisation	a) The growth of new blood vessels within a wound to an area that is relatively ischaemic. b) A surgical procedure to restore blood flow to an ischaemic body part.
Rigid cast dressing (RCD)	An RCD is a hard synthetic dressing moulded to fit over the residuum. The RCD is necessary as it helps to: prevent excess swelling (oedema) in residuum, reduce pain in residuum, protect residuum from external trauma, assist in wound healing, shape and desensitise residuum in preparation for prosthetic fitting.
Rubor	Red or purple colour often accompanied by swelling, heat and pain.
Sanguinous	Frank or heavily blood stained.
Scab	An incrustation over a wound, vesicle or pustule formed by the dried discharge. Scabs are found on superficial or partial-thickness wounds normally rusty brown in colour.
Scar	A mark in the skin or flesh made by a wound or ulcer and remaining after the wound or ulcer has healed otherwise known as a cicatrix.

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Scar – Hypertrophic	An enlarged, thickened scar due to increase in size of constituent cells. Hypertrophic scars remain within the boundaries of the original wound and can regress over time.
Scar – Keloid	Abnormal scar tissue that continues to grow and exceeds the boundaries of the original wound. The scar remains red, raised and smooth. Due to excessive fibrous tissue deposition.
Secondary intention healing	Wounds where the margins cannot be re-approximated. Healing occurs through granulation tissue formation, wound contraction and epithelialisation.
Seroma	A collection of serous fluid within a wound.
Sero-purulent	Wound exudate comprised of a mixture of pus and serum.
Sero-sanguinous	Light pink wound exudate that contains serum and blood.
Serous	Clear yellow, thin wound exudate.
Sinus Tract	A narrow, elongated channel from a deep infection to the skin. A tunnelling or a narrow opening or passageway underneath the skin that can extend in any direction through soft tissue and results in dead space with potential for abscess formation.
Skin graft	The transfer of a healthy piece of skin from one site to another. Can be partial thickness (split skin graft) or full thickness.
Skin Stripping	Loss of the epidermis from removal adhesives in dressings or tapes.
Skin Tear	A traumatic wound that results from the separation of the epidermis from the dermis, or the epidermis and dermis from the subcutaneous tissue and is usually related to friction and/or sheer combined with a blunt force.
Skin tear Realign:	To replace the skin or flap into the normal anatomical position without undue stretching.
Skin tear Linear	A skin split or the skin splitting in a straight line.
Skin tear Flap:	A segment of skin or skin and underlying tissue that is separated from the underlying structures.
Slough	Non-viable tissue within a wound bed. Usually whitish-yellow in colour. Dead tissue usually yellow in colour and can be stringy in appearance. Can be a source for bacteria and should be removed. Autolytic debridement is often the chosen approach to remove the necrotic tissue. Should not be mistaken for fibrin.
Splinting Effect	NPWT can be used to immobilise wounds often termed 'splinting' or stabilising effect for certain wounds e.g. sternal, abdominal wounds and skin grafts. Continuous therapy should be used in order to facilitate the splinting effect thus minimising movement and stabilising the wound bed.
Strike-through	Wound exudate that leaks through the outermost layer of bandage or dressing. Indicates the need for a more absorbent dressing regimen or more frequent dressing/wound reviews. Provides a possible portal of entry for micro-organisms to a wound. Refers to wound drainage that becomes visible on the outside of dressings.
Swab / Culture	A specimen collection of fluid (wound) to determine number and type of bacteria present. A wound should be cleansed prior to a swab being taken
Swelling	Presence of abnormality large amounts of fluid in the interstitial space.
Telangiectasia	Thread like veins in small bunches.
Tensile Strength	The strength of a closed or healed wound in terms of the greatest stress the tissues can bear without tearing. Tissues over a healed wound are approximately 80% as strong pre-injury. The amount of pressure that can

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	be applied without breaking the tissue. The term is used in relation to the strength of a wound post healing.
Thrombophlebitis	Inflammation of a vein accompanied by formation of a clot.
Tissue Engineering	Construction of tissues outside the human body.
Tissue Tolerance	The amount of pressure a person can withstand before capillary occlusion.
Toe Brachial Pressure Index (TBPI)	A procedure to determine arterial perfusion in the feet and toes by measuring the systolic pressure in the arm and the great toe.
Topical	Applied to the surface e.g. of the wound.
Total Contact Cast	A fibreglass device/cast often used to support the healing of diabetic foot ulcers (neuropathic ulcers) by redistributing the weight along the entire surface of the foot. The lower limb is encased in plaster of Paris to protect the area from trauma and provide an even pressure distribution.
Transcutaneous Oxygen Monitor (TOMs)	Is a non-invasive monitoring of the oxygen tension in the skin.
Tri-phasic sound	The normal sounds heard on a handheld Doppler for assessing blood flow.
Ulcer	A break in the skin or mucous membrane with the loss of the surface tissue.
Undermining	Tissue destruction underlying intact skin along wound margins.
Urticaria	A skin condition which appears as small red raised lumps in a localized area usually associated with allergy.
Vasculitis	Inflammation of a blood vessel. May lead to tissue ischaemia and tissue breakdown.
Vasoconstriction	Constriction or narrowing of the blood vessels.
Vasodilation	Dilation or widening of blood vessels.
Venous Hypertension	Due to the inability of the veins in the lower legs to return the blood to the heart because of incompetent venous valves, the build-up of fluid creates a high pressure within the lumen of the veins.
Venous Insufficiency	Inadequate venous blood return from the legs due to incompetent venous valves and/or underlying venous pathology.
Venous Stasis	Impairment (slowing) of venous flow from the lower extremities.
Venous Ulcer	Wound on the lower extremity caused from venous insufficiency.
Wound	A breach in the internal and/or external tissue of the body due to accidental (i.e. pressure injury) or intentional trauma (i.e. surgery) or an underlying disease process (i.e. arterial/venous insufficiency, neoplasm etc.)
Wound contamination	The soiling or pollution by inferior material, as by the introduction of organisms into the wound. A wound containing potentially harmful bacteria.
Wound Bed	The lowest viable surface of a wound.
Wound Care Expert	A person with advanced training in wound management and recognised within the facility e.g. CNC wound care, CNC Stoma and wound care, Nurse Educators.
Wound contraction	In wound healing, contraction occurs around the edges of the wound causing the wound size to become smaller. It is important to measure wounds to identify change over time; healing or deterioration.
Wound Management	Refers to: <ul style="list-style-type: none"> • Planned intervention • Regular assessment • Regular evaluation • Education of patient/caregiver

Wound Margin	Rim or boarder of a wound.
Wound repair	The healing process: partial-thickness healing involves epithelialisation; full-thickness involves granulation tissue formation wound contracture and epithelialisation.
Wound, Full Thickness	A wound which extends through the epidermis, dermis & subcutaneous tissue, may expose bone or tendon.
Wound, Infected	A wound in which harmful bacteria have invaded the host and are producing local and systemic indicators of infection, such as redness, pain, increased temperature, purulent exudate, malodour, etc.
Wound, Partial Thickness	A wound which extends through the epidermis and into but no through the dermis.

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