Complex Wound Care Procedures
Appendix 1: Factors that Impair Wound Healing

Definition of Terms

Factors that impair wound healing fall into 2 categories:

Intrinsic - factors relating to the participant

Extrinsic - external factors affecting healing

Intrinsic Factors

Health status: Certain factors in general health can affect wound healing. These include cardiovascular disease, arteriosclerosis, peripheral vascular disease, metabolic disorders, inflammatory disorders, cancer, and immobility.

Age: healing is slower in older people because of a slower metabolism, thinner skin and less elasticity.

Body build: both obesity and debilitation can adversely affect healing (**Obesity** is associated with immobility, diminished peripheral blood flow. Thin and debilitated participants can lack energy stores to maintain metabolic process).

Lifestyle factors: Smoking reduces blood flow; alcohol abuse can result in liver damage and digestive disorders.

Nutritional status: wound healing requires extra intake of protein, calories, vitamins, and essential minerals. Adequate fluid intake is required to maintain cellular hydration.

Extrinsic Factors

Mechanical stress: can create a wound or disrupt the healing of an existing wound. Such mechanical forces can include pressure, friction, and shearing.

Debris: includes necrotic tissue, scabs, excess slough, fibres, and suture fragments.

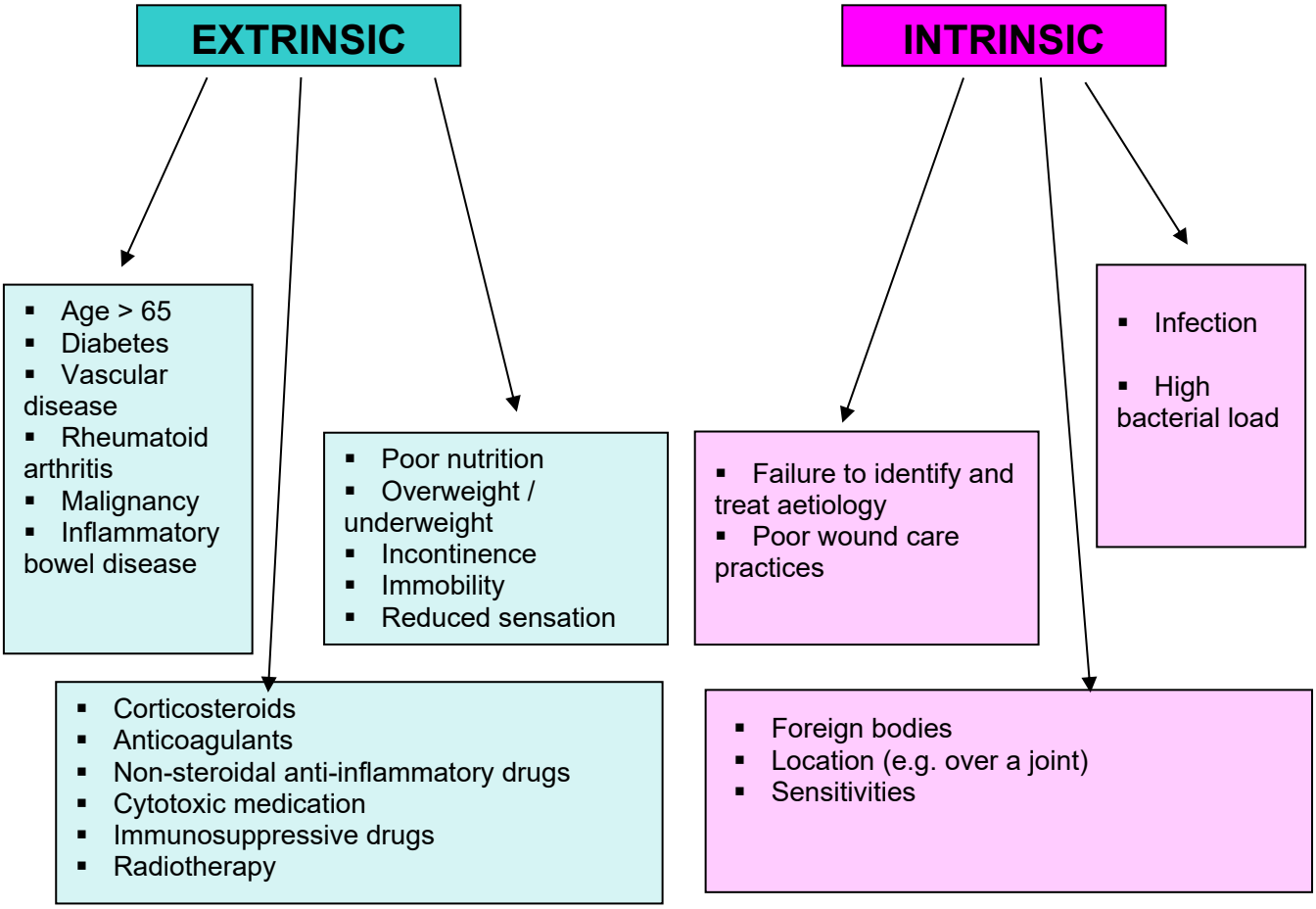
Temperature: a temperature of 37 degrees Celsius is optimal. Temperature extremes cause tissue damage.

Desiccation (causes cell death) or maturation (causes excessive exudates and weakens the wound edges): both excessive dryness and excessive moisture can adversely affect wound healing.

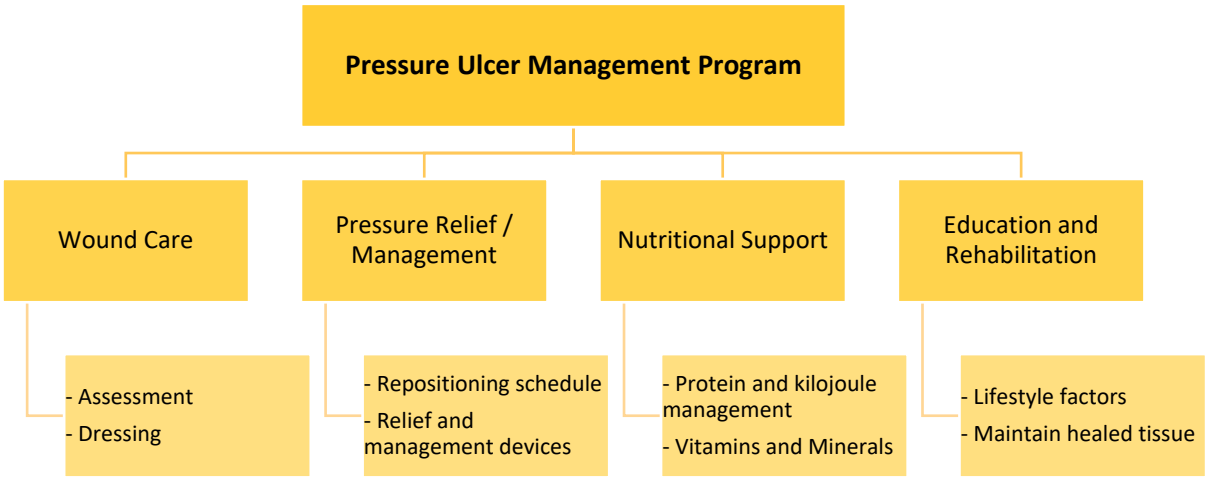
Infection: slows wound healing by release of bacterial toxins that affect fibroblast activity and prolongs the inflammatory phase.

Chemical stress: some topical antiseptics are cytotoxic and can damage healing tissue.

FACTORS THAT CAN IMPAIR WOUND HEALING FLOWCHART



Complex Wound Care Procedures
Appendix 2: Pressure Ulcer Management Program



Complex Wound Care Procedures
Appendix 3: Skin Tear Management

Procedure

Staff are to manage skin tears using the **STAR** acronym:

S – Stop the bleeding & clean
- Select an appropriate cleanser
- Assist bleeding control
- Clean the wound bed

T – Tissue Alignment
- Align the skin flaps (if possible) over the wound bed

A – Assess and dress
- Complete a holistic health assessment
- Inspect the surrounding skin
- Categorise the skin tear according to the STAR classification
- Draw an arrow on the dressing, indicating the direction of the skin flap.

R – Review and re-assess
- If the skin flap is pale and dusky/darkened, reassess within 24-48 hours
- Document the determined date for review and dressing change
- Remove the dressing in direction of the arrow
- Monitor for changes in the wound status by observing the wound pictures (taken by a camera) on the assessment chart
- Assess maintenance of the overall skin integrity

Complex Wound Care Procedures
Appendix 4: Pressure Area Management

Procedure

Registered Nurses should identify participant's pressure area risks as part of intake assessment and during *Complex Wound Care Support Plan* reviews (including preventative pressure area care strategies). If a pressure injury has been identified as part of reviews, staff are to complete an *Incident Report*, a *Complex Wound Location and Evaluation Chart* and classify the stage of the pressure injury. Pressure injuries are classified from Stage 1 to Stage 4.

Staff in direct care of a participant who is at risk of developing pressure sores should adhere to the participant's skin integrity care plan.

Stage	Description	
Stage 1	Intact skin with observable changes including areas of persistent redness.	
Stage 2	Partial thickness skin loss involving epidermis and/or dermis.	
Stage 3	Full thickness involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.	
Stage 4	Full thickness skin loss with extensive tissue destruction to muscle, bone, or supporting structures i.e. tendon, joint capsule. May have undermining or sinus formation.	

Complex Wound Care Procedures
Appendix 5: Selection of Wound Dressing Products

Procedure

When selecting appropriate wound dressing products, staff should refer to the participant's *Complex Wound Care Support Plan*, and consider the following goals:

- reduce the pressure and shear forces
- management of exudate
- prevention of contamination in the wound by ensuring the principles of aseptic techniques and hand hygiene is applied during all dressing changes.
- create a moist wound environment

The goals when selecting the most appropriate dressing is to:

- provide a barrier to bacteria
- absorb excess exudate
- be atraumatic on removal
- allow gaseous exchange
- provide thermal insulation
- protect the wound from further damage

See also Wound Dressing Guide

Complex Wound Care Procedures
Appendix 6: Wound Treatment Guide

Procedures

Wound Bed Preparation

The aim of the wound bed preparation is to remove barriers to wound healing by:

- Creating a vasculated wound bed by removing necrotic tissue and slough
- Reduce the inflammation or infection, and
- Manage the exudate levels to avoid maceration or desiccation

To prepare the wound bed, the **TIME** framework is to be utilised by staff:

T – Tissue non-viable or deficient

- Is removal of necrotic/sloughy tissue needed?
    - If Yes:

      Clinical Action: Remove necrotic tissue or slough present
      Clinical Process: Debride

I – Infection and/or Inflammation

- Is the wound infected?
    - If Yes:

      Clinical Action: Remove or reduce bacterial load
      Clinical Process: Topical antimicrobials, debridement of devitalized tissue

M – Moisture balance

- Do I need to hydrate the wound, absorb exudate, or maintain exudate?
    - If Yes:

      Clinical Action: Risk of desiccation. Restore moisture balance.
      Clinical Process: Absorb exudate or add moisture to dry wound

E – Edge of wound:

- Non-advancing or undermined

  Clinical Action: Address T/I/M issues and reassess after 2 weeks. If there is minimal improvement, report to the GP and consider referral to a wound specialist.

Complex Wound Care Procedures
Appendix 7: Incident Report Guide

Procedures

If a wound is discovered during service delivery, the nature and details of the wound must be reported to the Registered Nurse. If the wound was caused by a trauma, such as Skin Tears, Bruise or Pressure Sores, an *Incident Report* must also be completed.

Support workers must apply first aid (if qualified), complete an *Incident Report* and report to the Registered Nurse. The Registered Nurse will then assess the wound, create a *Complex Wound Care Support Plan,* and monitor the wound.

The Registered Nurse is responsible for:

- monitoring the wound
- amending the participant's *Complex Wound Care Support Plan* (in consultation with the participant and/or representative) and
- making referrals as required to Wound Specialists

Document Control

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Version History		
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