WOUND MANAGEMENT PROTOCOLS

Goal:
To provide best practice in the prevention and treatment of wounds and ulcers. To develop and implement wound care management plans in consultation with all stakeholders.

Procedure:
Generally, a separate wound care plan is to be generated for each wound.

The resident’s LMO is to be notified of all wounds and should review treatment. The LMO to be consulted regarding additional review by wound specialists or referral to clinics. The LMO should document findings and treatment in medical notes. The resident and/or their representatives and the LMO are to be informed of any changes to skin integrity and consultation to be documented in Nursing Progress Notes. RN to ensure that all wounds considered to be chronic are documented in medical notes by the LMO and aim of treatment is documented e.g. to heal, or palliative measures.

Wound Photographs:
Wound photographs to be taken:
✓ Monthly provided consent given (NB Consent form to be used)
✓ Where there is deterioration or change to wound status
✓ Immediately before transfer to another health care facility
✓ Immediately after re-admission from another health care facility unless resident arrives in facility late in the evening or LMO / hospital transfer instructions state otherwise
✓ On change of dressing routine

Consider for Referral to Specialist:
✓ Non-healing (wound not responding to treatment following approximately 3 week period)
✓ Discolouration, vascular / bone involvement
✓ LMO request
✓ Where it is considered clinically beneficial

EEN / RN to liaise with FMT, when referral is required.

For acute episodes refer to LMO / Hospital

Documentation:
✓ Entry in Nursing Progress Notes required when:
  o Wound noted to have developed
  o Wound has healed
  o Following wound deterioration or hospital intervention or infection
  o Short summary of wound status monthly – wound care plan will record all other wound management and progress
✓ Wound Care Plan to be developed and updated regularly and as interventions change
✓ Dimensions of wound to be noted every 7 days and documented
Nutritional Status:
- All residents with pressure ulcers must have nutritional status reviewed monthly (refer to weights & information from care staff regarding intake)
- Supplements to commence in all cases unless medical / clinical issues dictate otherwise
- When pressure ulcer has healed and normal oral intake deemed to be adequate, then supplements may be ceased

Pain Management:
- Pain control must be assessed and monitored daily with appropriate actions / interventions taken
- Changes in analgesia should be monitored for effectiveness

Wound Register/Report:
- All wounds entered in Manad care plans automatically appear on report.

Skin Tears:
- All skin tears need to be photographed
- If treatment for skin tear requires more than simple steri strips, then wound care plan to be generated
- Do not force or stretch skin when applying steri strips and simply apply one row of steri strips across skin tear (do not cross steri strips)
- All skin tears to be graded

Refer to Pressure Ulcer Prevention Guidelines and Wound Manual for further information on the prevention and management of wounds.
Pressure Ulcer Prevention Guidelines to be adhered to in the care planning of skin integrity management.