PPG-02151

Regional Wound Care

Area	Wound Care			
Section	General			
Subsection	N/A			
Document Type	Policy			
Scope	All Clinical Staff			
Approved By		**Original Effective Date**	**Revised Effective Date**	**Reviewed Date**
Treena Slate, Regional Lead Acute & Chief Nursing Officer		2021-Dec-22	2023-Aug-23	2023-Aug-23

DEFINITIONS

Best Practice: The ability to identify a clinical concern and determine the best outcome by identifying the best evidence available, evaluating client risk factors, and recognizing limitations.

Chronic wound: A wound that does not proceed through the normal stages of healing in an orderly fashion, but becomes stuck in one phase.

Client: An individual and/or their family/care provider who accesses and/or receives health care related services from a Prairie Mountain Health (PMH) facility or program. Clients may be patients in an acute care or transitional care setting, residents in a personal care home or clients in a community program or facility.

Complex wound: A wound that does not respond to conventional treatment, and is caused by co-morbidities, or has one or more complicating factors (e.g., palliative wounds, diabetic foot ulcers).

Healability of a Wound: Using assessment data to determine if a wound is healable, maintenance, or nonhealable.

- Healable – a wound in which causes and co-factors that can interfere with healing have been removed/optimized, and there is adequate blood supply (e.g., a pressure injury where pressure and other factors, such as incontinence and nutrition are managed).
- Maintenance – a wound that has healing potential but causes and cofactors that can interfere with healing have not yet been removed/optimized (e.g., neuropathic diabetic foot ulcer where the client is unable to obtain pressure redistributing footwear or non-weight bear to the affected foot).
- Non-healable – a wound in which causes and co-factors that can interfere with healing cannot be removed and/or there is inadequate blood supply (e.g., a fungating malignant lesion secondary to breast cancer).

Health Care Professionals (HCPs): Refers to all regulated Health Care Professionals. This will include those who promote and preserve health, who diagnose and treat disease, manage health and professionals with specific areas of competence.

Level 1 Wound Care Education: Education involving a basic overview of causes, prevention, assessment and management of wounds. This is required education for all HCPs involved in the care of clients with wounds or at risk for developing wounds as per Required Education (PPG-00729).

Level 2 Wound Care Education: Advanced 2-day education on specific wound topics related to wound care. Addresses specific wound care assessment, prevention, and management issues including:

- Pressure Injuries;
- Diabetic Foot Ulcers;
- Skin Tears;
- Venous/Arterial/Mixed Lower Leg Ulcers.

Prescriber: Licensed HCP with prescribing authority recognized by the College of Pharmacists of Manitoba and the HCPs regulating body. This may include physicians, dentists, nurse practitioners, extended practice registered nurses, clinical assistants, physician assistants, graduate medical students on the educational register or other regulated prescribers.

Unregulated Health Care Provider: Health Care Aide/Home Care Attendant (HCA), who may or may not be certified, that provides direct client care and environmental support within the established standards of care, policies, and procedures. The HCA functions in meeting the special and changing needs of clients and assisting them in reaching and maintaining optimum health and independence within the limits of their abilities and skill sets.

Wound Care Champion (WCC): An HCP who has completed Level 1 and Level 2 Wound Care Education.

PURPOSE

To provide an interdisciplinary, standardized, and collaborative approach to prevent, assess, and manage wounds. Additionally, to clarify the roles and decision-making authority of HCPs regarding the prevention and treatment of wounds.

POLICY STATEMENT

All HCPs involved in the prevention, assessment, and treatment of wounds will follow the principles outlined in this policy. This policy does not replace sound clinical judgement.

A HCPs scope of practice will determine roles and responsibilities in the prevention, assessment and treatment of wounds. Level 1 Wound Care Education is required for all HCPs who are responsible for the prevention, assessment, and treatment of wounds. HCP education requirements are determined by unit/program/department, as outlined in Required Education and Education Requests (PPG-00729).

HCPs responsible for prevention, assessment, and treatment of wounds will follow Wounds Canada's Best Practice Guidelines accessible on the Wound/Ostomy shared page on the PMH Intranet. A Prescriber's order is **NOT** required for wound care, dressing selection, and/or adjusting a wound treatment plan, as supported by the applicable regulatory bodies. **NOTE:** Compression therapy, and negative pressure wound therapy, are exceptions to this as an order is required to initiate and discontinue these therapies. HCPs are responsible to communicate with the interdisciplinary team and document appropriately when adjusting a wound treatment plan.

RESPONSIBILITIES

The Health Care Professional:

- Is accountable for maintaining competence and current knowledge related to the provision of wound care;
- Provides wound and skin care using best practice guidelines;
- Accepts responsibility and accountability for their own actions in the provision of wound care;
- Has sufficient knowledge, skill, and judgment to determine the appropriateness of providing wound care to a particular client;
- Has sufficient knowledge, skill, and judgment regarding wound and skin assessment (including wound etiology), the selection of wound care products and appropriate utilization of wound care products;
- Is knowledgeable about available resources to support the provision of wound care (such as UpToDate, Elsevier Clinical Skills, etc.);
- Communicates effectively regarding wound assessment and wound treatment plan;
- Documents all wound care and wound assessments on the applicable wound flowsheet (e.g., Wound Assessment and Treatment Flowsheet [PMH590]);
- Seeks consultation in situations where the client situation is complex, and as outlined below in 'Referral';
- Consults a Prescriber for:
    - Wounds with compromised arterial perfusion;
    - Advanced wound therapies;
    - Wounds that require infectious diseases management;
    - Complex dermatological presentations;
    - Wounds that require surgical intervention;
    - Negative Pressure Wound Therapy (NPWT);
    - Compression therapy;

  Note: Following consultation, a Prescriber's order is **not** required for ongoing wound dressing selection and adjustments of the wound treatment plan (with exception of compression therapy and NPWT).
- Who has completed Level 1 Wound Care Education:
    - Initiates wound prevention strategies;
    - Independently assesses, initiates, and documents the treatment of wounds with and without clinical signs and symptoms of infection;
- A Wound Care Champions (WCCs):
    - Assesses, plans care, recommends, and initiates treatment for all local wounds;
    - Serves as a wound care resource to their peers in the prevention, assessment and management of wounds;
    - Helps to facilitate wound care according to best practice guidelines in their organization and area of practice;
    - Maintains competence and current knowledge including seeking out learning opportunities and education;

Unregulated Health Care Provider

- Participates in, and completes education and/or training related to skin and wound care, as per individual program requirements and Required Education (PPG-00729);
- Utilizes applicable resources related to skin care in order to optimize skin health and promote healing;

- Completes observations during daily care; documents and reports any observations made that are pertinent to the client in a timely way (e.g., areas of skin breakdown, redness/discolouration, new reports of pain by client, nutritional intake).

Facility/Unit/Program Manager or Designate:

- Ensures required Level 1 Wound Care Education is completed by all HCPs at the site/unit/program.
- Ensures at least one WCC is available as a resource for wound prevention, assessment and management.
- Identifies and supports staff to obtain additional wound education as needed.
- As required initiates multi-disciplinary client care conferences to help develop a consistent plan of care for more complex wounds/situations. The care conference is held at a mutually agreed upon time, as needed, ideally with client/family involvement.
- Ensures appropriate wound care supplies and products are available to staff at point of care.

Regional Wound Care Coordinator/Wound, Ostomy, Continence Nurse

- Provides/facilitates regional and site/program specific wound care education, collaborating with clinical education and/or site/program manager as needed.
- Receives and manages wound care referrals.
    - Prioritizes and responds to referrals accordingly;
    - Communicates with sending program to request more information as needed;
    - Provides written recommendations (on Interdisciplinary Progress Note) via fax or email based on priority.
- Acts as a regional resource regarding skin and wound care for PMH staff.

PROCEDURE

Assessment

- Initial wound assessment determines the goal of care, which includes determining if the wound is healable, nonhealable, or maintenance.
- For all wounds on a lower limb, a vascular assessment is completed (e.g., Ankle Brachial Pressure Index) as well as a Lower Leg Assessment (PMH1528).
- A wound assessment is completed at every dressing change based on Wounds Canada's Best Practice Guidelines (accessible on the Wound/Ostomy shared page). The wound flowsheet is used for documentation of assessment and as a guide for the necessary components of a wound assessment (e.g., Wound Assessment and Treatment Flowsheet [PMH590]). If further documentation is required document in the appropriate area of the client health record (e.g., Interdisciplinary Progress Note).
- Wound measurements are done 'nose to toes', meaning the length is measured from the client's head towards the feet. The exception to this is surgical wounds, which are measured as the length being the length of the incision, with the width being perpendicular to the length.
- Measure wound depth with a sterile probe (such as a sterile cotton-tipped applicator) placed in the deepest part of the wound.
- Assess for tunneling and undermining by placing a normal saline-dampened sterile cotton-tipped applicator or sterile probe along the wound edge and insert into the dead space until resistance is met or entire applicator is inserted. When undermining is present, the direction (using the clock method) and extent (measured in cms) should be documented. For example: 2 cm. undermining present from 6 to 9 o'clock.
- The Wound Bed Preparation Paradigm (see Appendix A) is used to guide assessment and develop wound treatment plans. This includes but is not limited to consideration of nutrition, comorbidities, pressure offloading, perfusion, pain, client specific concerns such as smoking, etc.

- The wound is assessed for signs of critical colonization using the NERDS acronym; if three or more of the signs/symptoms are observed, critical colonization is considered to be present.
    - **N**on-healing wound – wound is non-healing despite appropriate interventions.
    - **E**xudative wound – an increase in exudate can be indicative of bacterial imbalance.
    - **R**ed and bleeding wound – if wound bed is bright red with exuberant tissue and bleeds easily, bacterial imbalance can be suspected.
    - **D**ebris in the wound – necrotic tissue and debris in the wound are a food source for bacteria and can encourage bacterial imbalance.
    - **S**mell from the wound – smell can be related to bacterial by-products caused by tissue necrosis associated with an inflammatory response, and indicative of wound-related bacterial damage.
- The wound is assessed for signs of infection using the STONEES acronym; if three or more of the signs/symptoms are observed, infection is considered to be present.
    - **S**ize is bigger – increased size may be due to deeper and surrounding tissue damage by bacteria.
    - **T**emperature increased – temperature is increased with surrounding tissue infection.
    - **O**s (probe to or exposed bone) – there is high incidence of osteomyelitis if bone is exposed or if bone can be probed.
    - **N**ew areas of breakdown – satellite areas of skin breakdown that are separated from the main wound.
    - **E**xudate – exudate can increase and become purulent with increased bacterial burden and inflammatory response.
    - **E**rythema/Edema – inflammation leads to vasodilation (erythema) and the leakage of fluid into the tissue (edema).
    - **S**mell – bacteria that invade tissue have a foul odour, therefore this can indicate potential associated tissue damage.
- A complete wound assessment, including wound measurements, is completed at initial assessment and at the following intervals (at minimum), unless clinically indicated to be completed sooner:
    - Healable wound – once every week;
    - Maintenance wound – once every 2 weeks;
    - Non-healable wound – once every 2 weeks.

Care of the wound bed

- Cleansing of the wound occurs at each dressing change.
    - Options exist for wound cleansing techniques. One option for cleansing wounds is to cleanse the wound bed (including wound edges) with intent using gauze moistened with appropriate cleansing solution to loosen superficial devitalized tissue, wound debris, and biofilm. Use gentle force as necessary and as tolerated. Cleanse minimum 10-20cm periwound sufficiently to remove scales and callus if present. Caution is exercised when cleansing inflammatory wounds (e.g., pyoderma gangrenosum, vasculitis, etc.) as well as with fragile newly epithelialized tissue, which require a gentler approach.
    - Another wound cleansing technique is to irrigate well with normal saline or sterile water until clear returns. Ensure that fluids used for irrigation are adequately drained from wound space (may require client repositioning). For more information on wound irrigation reference Wounds Canada Best Practice Recommendations for the Prevention and Management of Wounds.
    - Use appropriate cleansing solution such as normal saline, sterile water, or commercially produced wound cleanser (ideally a non-cytotoxic wound cleanser with surfactant).

    Note: commercially produced wound cleansers may or may not be available in PMH according to provincial contract.

- Use fluid that is at least at room temperature for cleansing (colder solutions can slow down cellular repair).
- Do not use skin cleansers for wound cleansing (e.g., chlorhexidine surgical scrub, povidone detergent).
- Do not use topical antiseptic solutions that may cause cytotoxicity (e.g., sodium hypochlorite solution, hydrogen peroxide, acetic acid).

Note: Topical antiseptic solutions (e.g., povidone iodine, aqueous chlorhexadine 0.05%) should be reserved for wounds that are non-healable, or those in which the local bacterial burden is a greater concern than the stimulation of healing short term (under direction of prescriber or wound care coordinator/wound, ostomy, continence nurse).

- Document the wound treatment plan on the applicable wound flowsheet (e.g., Wound Assessment and Treatment Flowsheet [PMH590]). Wound treatment plans are developed using Best Practice, a thorough wound assessment, and the wound bed preparation paradigm (see Appendix A). Resources used to support the development of wound treatment plans include the Wounds Canada Best Practice Guidelines, as well as the Wounds Canada Product Picker in conjunction with the PMH wound care formulary for advanced wound care products (all accessible on the Wound/Ostomy shared page).
- Follow a wound treatment plan for 2 weeks before revising, unless clinically indicated to reevaluate sooner.
- If there is no potential for healing due to inadequate blood supply, moist interactive local wound care and compression are contraindicated. The application of topical antiseptics (e.g., povidone iodine) to dry the wound and prevent bacterial invasion is initiated.
- Wounds Canada's Best Practice Guidelines are considered when managing wounds of specific etiologies such as, diabetic, venous, arterial, pressure injury, skin tear, and moisture associated skin damage wounds (see Wound/Ostomy shared page for inclusive list of guidelines).
- Debridement (autolytic, mechanical, enzymatic, biologic, conservative sharp) is used to reduce or remove dead/necrotic tissue in a healable wound as appropriate per Wounds Canada's Best Practice Guidelines. Mechanical debridement using wet-to-dry dressings is NOT best practice and is NOT recommended due to damage caused to healthy tissue and pain to the client.

Note: Conservative sharp wound debridement requires specialized training. Clinicians must ensure that they have the necessary skills and education to perform the task, the skill is within their regulatory scope of practice, AND there is PMH policy in place to support them.

- Do not debride when:
  - There is no necrotic tissue in the wound bed;
  - The goal for the client is maintenance of the status of the wound, while providing comfort and preventing infection;
  - There is dry gangrene and/or inadequate blood supply (consult prescriber);
  - Ankle Brachial Pressure Index (ABPI) less than 0.5, and should be considered with caution for ABPI 0.5-0.69.

  Note: Vascular assessment is recommended for ALL ulcers in lower extremities prior to debridement to rule out arterial/vascular compromise; this includes ABPI (see Wound Prevention and Management Ankle Brachial Pressure Index [PPG-00975]). Debridement techniques may be considered along a continuum from least invasive (e.g., wound cleansing) to most invasive (e.g., sharp/surgical).
- If there is dry gangrene and/or inadequate blood supply (consult prescriber):
  - Dry, stable eschar on a lower limb/foot is to be kept dry;
  - Do not cleanse with normal saline or tap water;
  - Do not tub bath or soak;
  - Protect the wound during showering;
  - Paint the eschar and 2.5cm of periwound skin with povidone iodine 10%.

Manage the Closed Wound in the Maturation/Remodeling Phase

- Ensure that a closed wound is protected for an extended period of time based upon the presence of risk factors as well as the type and underlying cause(s) of the wound. A closed wound may not be fully healed for up to 2 years.
- Avoid hot water and excessive rubbing or friction over the closed area.
- Apply a moisturizer to the closed area. Avoid moisturizers with irritants (e.g., lanolin, fragrance).
- Protect the area from pressure, friction, shear, and moisture. Refer to OT/PT for reassessment of positioning, equipment, or devices as needed.
- Inspect the area frequently for any new skin breakdown and document assessment.
- Teach the client and/or family strategies to prevent recurrence, and document.
- Protective dressings may be indicated for protecting the area from breakdown during the maturation/remodeling phase; assess and implement on an individual basis.
- For clients with vascular insufficiency consult prescriber regarding appropriateness of potential long-term compression.

Referral

- Wound care referrals are initiated when additional assistance and expertise is required in caring for a client with hard-to-heal, complex, or non-healing wounds.
- Prior to completing a wound care referral, consult a WCC at the site/program level.
- Criteria for wound care referrals includes, but is not limited to:
    - Wounds that are not healing at the expected rate (e.g., a decrease in size of 20-40% in four weeks when the goal of care is to heal).
    - Wounds that deteriorate despite implementing Best Practice wound care. This includes identifying and treating the cause, and following a consistent and appropriate wound treatment plan based on wound assessment/need.
    - Wounds present longer than three months with no signs of improvement, despite implementation of Best Practice wound care.
    - Cause of the wound, or the reason the wound will not heal, is unknown.
    - Stage 3 or Stage 4 pressure injuries that have been reported as a Critical Incident as per Critical Incident and Incident with Review Reporting and Investigation (PPG-00093).
- Steps to complete referral:
    1. Complete the Wound Care Referral (PMH478) form. Incomplete referrals will not be reviewed until all applicable information is provided. Include with the referral:
        - Wound Assessment and Treatment Flowsheet (PMH590).
        - All applicable accompanying data (e.g., lab results, vascular reports).
        - Wound photos emailed to the Regional Wound Care Coordinator per Wound Prevention and Management Guidelines for Photography of Wounds (PPG-00111).
    2. Forward the completed Wound Care Referral (PMH478) form and associated documents to the email address or fax number indicated on the form.
    3. File Wound Care Referral form in the client's health record.'
    4. When referral response is received, it is reviewed by the HCP, placed in the client's health record, and communicated to the interdisciplinary team.

    Note: Referrals are reviewed and prioritized according to need. Upon receipt of an incomplete referral (PMH478), the Regional Wound Care Coordinator or Wound Ostomy Continence nurse will contact referring unit/site/program, notify of incomplete referral, and request information/documentation as required.

RELATED MATERIAL

Appendix A, Wound Bed Preparation Paradigm
Appendix B, Wound Management Flow Chart
PMH478, Wound Care Referral
PMH590, Wound Assessment and Treatment Flow Sheet
PMH1461, Ankle Brachial Pressure Index (ABPI) Worksheet
PMH1528, Lower Leg Assessment
PMHMSO.127, Treatment of Frostbite – Adult
PMHMSO.216, Adult Burn Trauma Clinical Decision Tool
PMHMSO.217, Pediatric Burn Trauma Clinical Decision Tool
PPG-00093, Critical Incident and Incident with Review Reporting and Investigation
PPG-00111, Wound Prevention and Management Guidelines for Photography of Wounds
PPG-00112, Wound Prevention and Management Pressure Injury Prevention and Treatment
PPG-00729, Required Education
PPG-00975, Wound Prevention and Management Ankle Brachial Pressure Index
Skin Care Formulary
Wound Care Formulary
Wound/Ostomy Shared Page
Wounds Canada Best Practice Guidelines (found on Wound/Ostomy Shared Page)
Basic Principles of Wound Management - UpToDate

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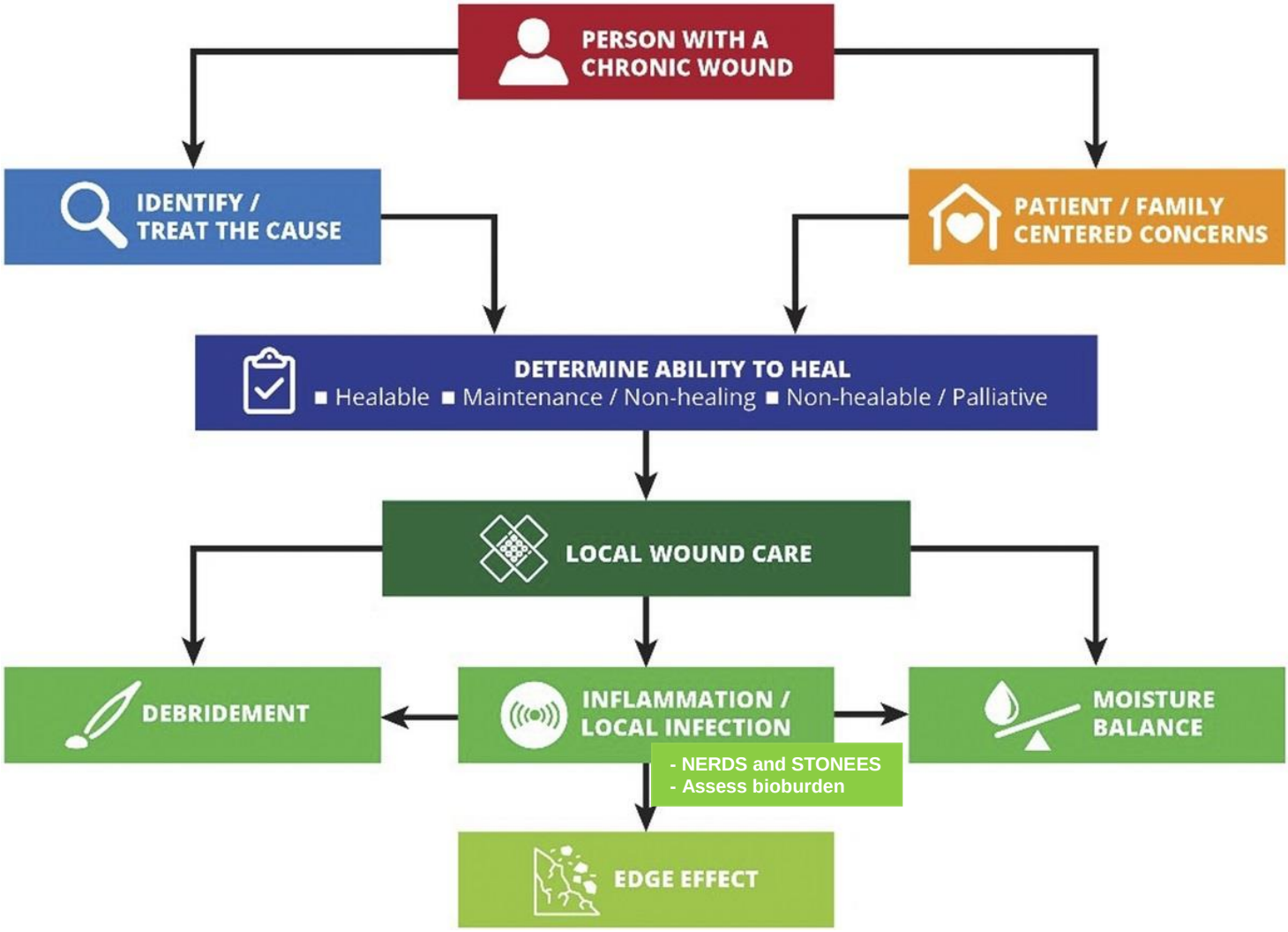
DOCUMENT HISTORY

Version	Changes
2021-Dec-22	New.
2022-Apr-11	Revised. Added PMHMSO.127, PMHMSO.216, and PMHMSO.217 to Related Material section.
2022-Oct-12	Revised. Inclusion of Wound management flow chart as an appendix, and responsibility of multidisciplinary care conference.
2023-Jun-28	Revised. Amalgamated with previous Wound Prevention and Management Care of the Wound Bed to include wound assessment, care of the wound, and care of the wound in the remodeling phase. Roles and responsibilities included for unregulated health care providers and wound care coordinator/wound, ostomy, continence nurse. Definitions updated. Appendix A added.
2023-Aug-23	Revised. Added wound measurement details.

Appendix A Wound Bed Preparation Paradigm



Adapted from: WOUND BED PREPARATION 2021 PARADIGM©WoundPedia 2021. Wound Bed Preparation 2021 Advances in Skin & Wound Care 34(4):183-195, April 2021. Accessed from https://journals.lww.com/aswcjournal/fulltext/2021/04000/wound_bed_preparation_2021.4.aspx 2023Jan26.

Appendix B – Wound Management Flow Chart

DID YOU KNOW:
If you are unsure of what dressing to choose, check out the **product picker tool** on the Wound/Ostomy page on the intranet.

A wound is identified, now what?

DID YOU KNOW:
Every wound needs a Wound Assessment and Treatment Flowsheet (e.g., PMH590) initiated and maintained. All wound care and wound assessments are documented on the Wound Assessment and Treatment Flowsheet.

Complete a thorough wound assessment with documentation using the Wound Assessment and Treatment Flowsheet (e.g., PMH590). Consider other factors such as nutrition status, frailty, comorbidities, mobility issues, etc., to guide decisions on management strategies, and document

DID YOU KNOW:
HCPs are responsible for prevention, assessment, and treatment of wounds following Wounds Canada Best Practice Guidelines. **A Prescribers order is not required for wound care or dressing selection.**
See policy PPG-02151 for situations where a Prescriber would need to be consulted.

Decide on an appropriate dressing and treatment plan.

WANT TO TALK IT OVER?
A list of Wound Care Champions located throughout our region is available on the Wound/Ostomy shared page. Wound Care Champions are a great resource for troubleshooting wound management questions.

Initiate plan and leave in place for **TWO weeks** whenever possible. If changing the plan, the reason must be documented.

Wound improves:
Continue treatment plan

Improvement not seen:
Complete thorough wound and client assessment. Reassess treatment plan and adjust accordingly.

DID YOU KNOW:
Wound care referrals are appropriate to initiate for additional assistance/expertise when caring for a chronic, complex, or non-healing wound after a thorough wound assessment has been completed and wound management has been implemented.

Criteria for referrals include, but are not limited to:

- Wounds that are not healing at the expected rate.
- Wounds that deteriorate despite implementation of Best Practice Wound Care.
- Wounds present longer than 3 months with no signs of improvement despite Best Practice Wound Care.
- Cause of wound, or reason it will not heal is unknown.
- Pressure injuries that have reached stage 3 or 4 status and have been reported as a critical incident.

NOTE: A Wound Care Champion should be consulted first before a referral to the Regional Wound Care Coordinator.

Consult with a Wound Care Champion and other interdisciplinary team members.

Improvement not seen:
Reassess treatment plan and adjust. Consider a Wound Care Referral (PMH478).

Required Education: Level 1 Wound Care Education is available on the Learning Management System (also known as L.M.S. or S.P.O.T.). See Required Education PPG-00729 for information on what is required for your role regarding wound care education.
More Education: Level 2 Wound Care Education is offered by the PMH Regional Wound Care Coordinator and is advertised when sessions are available on the Wound/Ostomy shared page and Prompt.
More Resources: Check out the Wound/Ostomy shared page, consult with the Wound Care Champions at your site, and when appropriate consult with the Regional Wound Care Coordinator/Wound, Ostomy, Continence Nurse.