



WOUND MANAGEMENT

INTRODUCTION

Infection of surgical wounds may be a serious complication leading to prolonged hospital stay, readmission, prolonged morbidity and occasional death.

PREVENTION

Wound infection may be prevented by:

- Preventing a patient acquiring virulent or resistant hospital flora (eg MRSA)
- Aseptic techniques in surgery
- Judicious use of antibiotic prophylaxis
- Proper post-operative wound management

WOUND CARE

The choice of dressing depends on wound type, position and size, and patient factors (eg allergy). Follow manufacturers' guidelines. Refer to in-house policies and surgeons' preferences. Do not mix chemical products. It is essential that a post-operative wound dressing is fully adherent and is not disturbed in recovery or on the ward. Dressings must not be taken down for at least 5 days after surgery unless there is a clinical indication such as strike through of blood or a suspicion of early infection (eg with *Streptococcus pyogenes*). Most infections become apparent around day 10 after surgery (although usually preceded by a period of non-specific fever) and may require re-exploration of the wound to drain pus and remove foreign objects such as stitch material. Antibiotics are poorly effective.

GUIDE TO WOUND CARE PREPARATIONS

Optimum wound dressings allow:

- A moist environment at the wound-dressing interface
- Non-adherence to the wound surface
- Thermal insulation
- Vapour permeability
- Impermeability to micro-organisms
- Freedom from particulate matter

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CHOICE

Choice considerations from those available (see below):

- Type: passive, interactive, or occlusive
- Accessibility of wound
- Range of size available
- Conformation to the wound
- Acceptability to the patient

NON/LOW ADHERENT DRESSINGS E.G. MELOLIN, N.A. ULTRA, RELEASE, MEPITEL

- Most are low adherent rather than non-adherent
- Can be used on their own on dry, lightly exuding wounds
- Do not absorb excessive exudate
- May require a secondary dressing
- Require securing with adhesive tapes, bandages or top dressing
- Some dressing products can stay in place for up to 7 days

SEMI-PERMEABLE FILMS E.G. OPSITE, TEGADERM

- Can be used in conjunction with hydrogels to rehydrate eschar
- Suitable for shallow wounds
- Films have no absorbent properties
- May cause adhesive trauma on fragile skin when removed
- Some dressing products can stay in place for up to seven days
- Valuable for covering intravenous line insertion sites

BARRIER FILM E.G. CAVILON

- A no sting protective transparent barrier film
- Indicated as a protective interface between the skin and bodily wastes, fluids and adhesive dressings and tapes
- Provides pain free protection on broken skin
- Is non cytotoxic and will not interfere with wound healing

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HYDROGELS E.G. NU-GEL, LNTRASITE


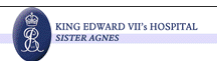



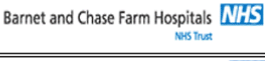





- High water content transmits moisture vapour and oxygen
- Donate water molecules to the wound surface - rehydrate non-viable tissue
- Do not damage underlying fibroblasts
- Absorb excess amounts of exudate
- Maintains a moist wound environment
- Indicated for use in sloughy and necrotic wounds
- Debrides the wound by rehydration and promoting autolysis
- Can be used at all stages of wound healing
- Easy to remove and atraumatic for the patient
- Cover with non-adherent/occlusive dressing

HYDROCOLLOIDS E.G. GRANUFLEX, DUODERM

- Consists of a self adhesive base which forms a gel on contact with exudate
- Allow gaseous exchange to take place at the wound surface
- Absorb light to moderate exudate
- Can be used on dry, necrotic or granulating wounds
- Enhance the growth of new blood vessels
- Require infrequent dressing changes
- Although bacteria grow within the colloid, this is not a disadvantage

ALGINATES E.G. KALTOSTAT, SORBSAN

- Main role is to absorb exudate so they should not be moistened before application to the wound
- Greatest use in heavily exuding wounds, even when infection is present
- Do not damage underlying fibroblasts
- Require a secondary dressing
- Possess haemostatic properties
- Can be left in place for 3-5 days, depending on the amount of exudate
- Available as a wound or cavity dressing

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SUGAR PASTE

- Applicable for deep infected wounds
- Bactericidal due to osmotic effect
- Consistency can be tailored to the site of a wound
- Does not damage underlying tissue healing
- Held in pace with a secondary superficial dressing

HYDROFIBRE DRESSINGS E.G. AQUACEL

- Consist of a soft non-woven fibre of sodium carboxymethylcellulose
- Directly absorbs fluid into the fibres which increase the fluid handling capacity of the dressing
- On absorption of fluid the dressing forms a soft cohesive mass of gel which can be removed in one piece from the wound bed
- Minimises excoriation and maceration of the skin at the edges of heavily exuding wounds
- Promotes moist wound healing
- Can be used under compression bandaging or hosiery

ENZYMATIC DRESSINGS E.G. VARIDASE

- Used for cleaning/debriding necrotic wounds
- Requires changing at least once daily
- Expensive
- Short shelf life
- Must be kept in a refrigerator
- May be covered by a film dressing
- Rarely indicated

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IODINE BASED POLYSACCHARIDE BEAD DRESSINGS E.G. IODOSORB, IODOFLEX

- Absorb exudate
- Can be used on sloughy wounds
- Indicated for use in infected wounds and for medium to heavily exuding wounds
- Rapidly inactivated in presence of pus
- Dressing changes colour when it requires removal
- Contra-indicated for use in patients with thyroid disorders

PARAFFIN GAUZE/TULLE GRAS (NON-MEDICATED) E.G. JELONET, PARATULLE, PARANET

- Requires frequent changing to avoid drying out
- Can adhere to granulation tissue, so should be applied in three layers
- May cause trauma to the wound bed when removed
- Requires a secondary dressing
- Only recommended for use on clean superficial wounds

DEODORISING DRESSINGS E.G. ACTISORB SILVER 220

- Indicated for use on malodorous, infected wounds
- Can be used on infected wounds
- Can be applied directly to the wound surface
- May be used over a non/low adherent dressing if adherence to the wound bed occurs
- Absorbs bacteria, eliminates offensive odour and reduces excessive exudate

TOPICAL ANTIBIOTICS E.G. METRONIDAZOLE GEL

- Can be used on malodorous or fungating wounds
- Requires frequent application
- Requires a secondary dressing
- Consider the use of systemic metronidazole

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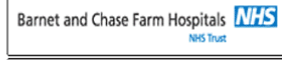
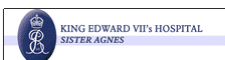
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TOPICAL ANTIBIOTICS AND ANTISEPTICS

- e.g. antiseptics - Chlorhexidine, povidone iodine, Inadine
- e.g. antibiotics - Metronidazole gel, silver sulphadiazine cream (Flamazine), mupirocin (Bactroban), fusidic acid (Fucidin)
- Recommended in only a few circumstances e.g. MRSA, infected wounds and burns
- Rarely indicated in hospital practice
- Select for resistance
- Antiseptics have been shown to damage healthy tissue and may not reduce bacteria to safe levels.
- Many antiseptics are deactivated by organic material e. g. slough
- Sensitivity reactions can often occur with repeated use

GROWTH FACTORS E.G. REGRANEX

- Promotes recruitment and proliferation of the cells involved in wound repair
- Enhances the formulation of granulation tissue
- Used for full thickness, neuropathic, chronic, diabetic ulcers
- Requires changing daily
- Not suitable for individuals below 18 years old
- Expensive


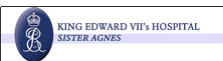


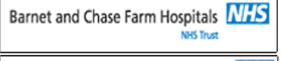




SILICONE DRESSINGS E.G. CICA-CARE, MEPIFORM

- Promotes hydration of the scar
- Used to reduce hypertrophic and keloid scarring
- Used to flatten scar tissue, increase elasticity and reduce discolouration

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SELECTING WOUND MANAGEMENT PRODUCTS FOR TYPES OF WOUNDS

WOUND TYPE	DRESSING CHOICE	WOUND TYPE	DRESSING CHOICE
FLAT, DRY	Low-adherent-release: N-A Ultra Vapour permeable films: Bioclusive	EPITHELIALISING	Vapour-permeable film- Bioclusive Hydropolymer- Tielle Lite Hydrogel - Nu-gel Low-adherent - NA Ultra, Mepitel
FLAT MOIST	Low-adherent-Release: N-A Ultra Vapour-Permeable film: Bioclusive Hydropolymer: Tielle Alginate: Kaltostat Non Medicated tulle: Jelonet Hydrogel: Nu-gel	GRANULATING	Hydropolymer- Tielle Lite Alginate- Kaltostat Hydrogel-- Nu-gel Low-adherent-Release or N-A Ultra if dry, lightly exuding Vapour permeable Film-- Bioclusive
EXUDING Low- moderate Exudate	Hydropolymer: Tielle Lite or Classic Alginate: Kaltostat, Hydrogel, Nu-gel	EXUDING Moderate – heavy Exudate	Alginate - Kaltostat Hydrofibre - Aquacel
EXUDING Heavy exudate	Alginate: Kaltostat Hydropolymer: Tielle Classic or Plus	EXUDING Deep wounds with a cavity	Alginate-Kaltostat packing Hydrogel-- Nu-gel VAC (Vacuum Assisted Closure)
SLOUGHY Sloughy cavity	Consider sodium chloride 0.9% cleansing and surgical debridement. Hydrogel: Nu-gel Hydropolymer: Tielle Alginate: Kaltostat Hydrogel: Nu-gel Alginate: Kaltostat	INFECTED (Please refer to Infection Control Team for advice)	Antibiotics e.g. systemic route Antibacterial e.g. Flamazine Antiseptics e.g. povidone iodine Inadine-cut into strips Actisorb Silver 220 - made into 'tea bag'
MAL- ODOROUS	Odour absorbing Actisorb Silver 220 Metrotop Gel: for fungating, malodorous tumours only	NECROTIC	Hydropolymer-Tielle Hydrogel- Nu-gel Varidase and Nu-gel Surgical debridement

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CHOICE OF DRESSING/PRODUCT FOR WOUNDS/WOUND TYPES

Discoloured, unbroken skin

Dry skin: simple bland moisturisers e.g. 50/50 cream, E45 cream, soft paraffin

Skin conditions associated with wounds: paste bandages

Skin subject to pressure or trauma: foam dressings; low adherent dressings; non-medicated tulle; vapour permeable films

Overgranulation tissue

Hydropolymer-Tielle

Terra-cortril (tetracycline and hydrocortisone) ointment

Lyof foam

Oedematous wounds

Compression bandages

Exercise, Elevation

Cavity wounds

If cavity present use Nu-gel (sloughy) or Inadine (infected)

Alternatively: foams, cavity wound dressings e.g. Allevyn, alginate ropes

Venous ulcers

Compression bandages elevation, exercise

Non/Low adherent dressing - Release or N-A Ultra

Paste bandages - to treat skin conditions

Arterial ulcers

Low Adherent dressing e.g. Release or N-A Ultra

Paste bandages to treat skin conditions

Exercise

Compression bandages are contraindicated

Venous/arterial ulcers

As for arterial ulcers except that light compression may be indicated

Pressure ulcers

Relief of pressure

Diabetic foot ulcer

Foot care, vascular assessment, pressure reducing management, callus removal, growth factors

Malignant, fungating wounds

Control bleeding, debride wound, treat odour

Reduce exudate and inflammation

Care for surrounding skin

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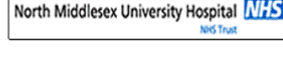
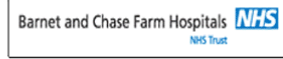
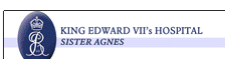
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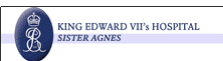


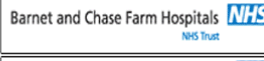




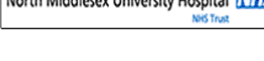
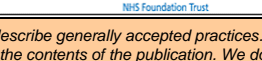
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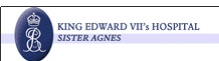


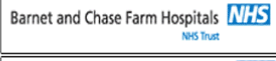

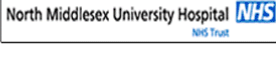

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WOUND MANAGEMENT PRODUCTS AVAILABLE

TYPE OF DRESSING	BRANDS	FREQUENCY OF DRESSING CHANGE	GENERAL INDICATION OF USE
Absorbent	GAUZES, DRESSING PADS, TOPPER (J&J)	As required	Secondary coverage to provide absorbency and insulation.
Paraffin Gauze/Tulle Gras	Jelonet (S&N)	As required to prevent drying out	Clean, superficial wounds e.g. dermabrasion or partial thickness burns
Low (reduced adherence)	RELEASE (J&J) N-A Ultra (J&J)	As required.	Dry or very lightly exuding wounds e.g. ulcers and granulating wounds
Vapour- permeable film	BIOCLUSIVE (J&J)	As required	Clean, shallow low exudate wounds - especially where useful to see wound bed. Secondary dressing over gels, alginates.
Hydrogel	NU-GEL (Hydrogel with Alginate) (J&J)	Every 1-3 days	Dry, sloughy or necrotic wounds. Sloughy cavities. Lightly exuding or granulating wounds. Cool wound, reducing pain. USE WITH MEDICAL SUPERVISION ON WOUNDS WHERE ANAEROBIC INFECTION IS PRESENT.
Hydropolymer	TIELLE Lite or Classic (J&J) TIELLE Plus	Daily initially, once exudate diminished leave up to 7 days	Light to medium exuding wounds, e.g. leg ulcers, pressure ulcers and for desloughing. NOT ON CLINICALLY INFECTED WOUNDS WITHOUT MEDICAL SUPERVISION. May adhere to dry, shallow wounds if left for extended periods. For moderate to heavy exudate.

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TYPE OF DRESSING	BRANDS	FREQUENCY OF DRESSING CHANGE	GENERAL INDICATION OF USE
Hydrogel + Hydropolymer	NU-GEL + TIELLE (J&J)	Daily if infected. Can be left up to 3 - 5 days according to wound type	Open, post-operative, granulating, cavity wounds (with no underlying tracts or sinuses) such as pilonidal sinus excision, dehisced surgical wounds, perineal wounds, pressure ulcers.
Alginate	KALTOSTAT - sheets - packing (cavity dressing) (Conva Tec)	Daily inspection. Change if reached maximum absorbency can reach twice-weekly changes quickly.	Bleeding and non-bleeding, heavily to moderately exuding wounds. Shallow or cavity wounds. (with a secondary dressing)
Dressings/ Products For prevention of Infection	INADINE (tulle impregnated with in Povidone-Iodine 10%) (J&J) FLAMAZINE CREAM (Silver sulphadiazine 10%)	Change when distinctive orange-brown colour changes to white. Max 4 dressings at same time Daily, under absorbent dressing	Superficial burns and skin loss injuries. Caution in patients with known sensitivity to iodine or thyroid patients who are not well controlled. Where infection may prevent healing e.g. burns
Prevention of infection. Absorption of odour	METROP GEL (contains Metronidazole 0.8%) (Seton)	Apply to wound 1-2 times daily and cover USE TUBE ONCE ONLY	De-odourisation of fungating malodorous tumours. Flat wounds - apply liberally. Cavities – smear on unmedicated paraffin gauze and pack loosely
- Sloughy - Infected	ACTISORB SILVER 220 (J&J)	Use every 1-7 days at first then weekly by using on top of low adherent dressing if required. Daily if infected. Can leave up to 7 days.	Presence of bacterial contamination, infection or odour e.g. superficial burn (N-A Ultra in between if bleeding, dry), fungating carcinomas as contains charcoal and silver. DO NOT CUT. Exuding and infected wounds, pressure ulcers, and leg ulcers, with a secondary dressing.

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WOUND CLEANSING

Prior to cleansing the wound the nurse should consider the following issues:

- What is the purpose of cleansing the wound?
- Does the wound need cleansing?
- What are the indications for cleansing the wound?
- What method should be used to cleanse the wound?
- Is an aseptic technique necessary?
- What solution should be used to cleanse the wound?

Although there is now a general move away from mechanical cleansing of the wound surface there are occasions when it is necessary to remove residues of slough or other debris from the wound or surrounding skin. The routine use of antiseptic solutions has little place in wound management (Value for Money Unit, 1996).

WOUND CLEANSING AGENTS

For routine wound cleansing, **normal saline** 0.9% is the preferred solution of choice. It should be warmed to body temperature (Thomas, 1990) before use to avoid lowering the temperature of the wound and impairing the healing process. However, the use of tap water for cleaning chronic wounds has been shown to have no detrimental effects to healing in any way (Young, 1995). To ensure fibres are not left in the wound irrigation should be carried out rather than swabbing the wound surface. However too low a pressure for irrigation may not be useful in removing exudate while too high a pressure may cause damage to granulating tissue. A variety of irrigation products are available and include steripods, sachets, aerosols, and syringes. Always read manufacturers instructions before use.

In some circumstances, the medical staff may request unfamiliar wound cleansing solutions. The following information should assist you with selecting the appropriate solution for wound cleansing based on current research based evidence. Notice that most are BAD for wound healing.

Acetic Acid 3%

Effective against *Pseudomonas aeruginosa* but short acting. Apply twice daily as a wet-to-dry dressing.

Can cause stinging

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Solutions containing cetrimide e.g. Tisept, Cetrimide, Savlon

Used for emulsifying and detergent properties for dirty wounds. Cytotoxic effect on fibroblast cells. May cause skin irritation and sensitivity. Use with caution

Chlorhexidine

0.05% solutions recommended for use on wounds. Effective against Gram-positive and negative organisms and some fungi, not spores. Sensitisation may occur. Avoid contact with eyes.

Hexachlorophane

Sterzac dusting powder used for *Staphylococcus aureus* colonisation of intact skin or small wounds. May be absorbed from large raw areas (eg burns) or in neonates and the may cause deafness.

Chlorinated solutions e.g. Eusol, Dakin's solution

Traditionally used as desloughing agents. Short shelf life. Rapidly de-activated. Require frequent changes of dressings. Chemically unstable. Adverse effects - delay healing, irritant, reduce capillary flow, depress collagen synthesis, cause over-granulation, localised oedema, cell toxicity. Use discouraged.

Dyes


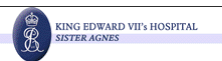
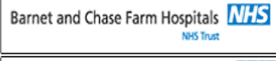


e.g. Brilliant green, gentian violet, mercurochrome, potassium permanganate. Traditionally used as astringents to dry up macerated skin around wounds. Inhibits wound healing. Use discouraged

Hydrogen Peroxide

Used to clean dirty, sloughy, infected, necrotic wounds, not recommended for clean wounds. May chemically interact with other topical medicaments. Contamination with organic material results in loss of effectiveness. Stings on application. May be caustic to wounds and surrounding skin. Check in-use dilution. Irrigated under pressure or into enclosed body cavities may cause oxygen embolus and surgical emphysema.

Povidone iodine e.g. Inadine, Betadine, Videne, etc.

Broad spectrum of antibacterial activity. Bacterial effect is reduced by contact with pus and exudate. Apply at regular intervals. Low risk of sensitivity. Do not use alcoholic solutions.

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Delays wound healing and risk of iodine toxicity if used in open wounds (Lawrence 1998).

Silver Nitrate 0.5% - 0.25% aqueous solution

Bacteriostatic, has a broad anti-bacterial spectrum. Application painless. No local sensitivity. Stains tissue.

May effect water and electrolyte balance and cause metabolic disturbances

Sugar. 50% caster, 50% icing sugar mixed to a paste with sterile water

Recommended for use in infected, dirty, malodourous wounds. Frequent packing of wounds is necessary - twice daily or more often. May cause bleeding when granulation tissue well formed. Non toxic effects. All pastes should be stored in a refrigerator.

Varidase

Facilitates cleansing of necrotic and infected wounds. Reconstitute the powder with sterile sodium chloride 0.9%. Stable for up to 24 hours if stored in a refrigerator. Can be injected under dry eschar or applied on the surface of scored necrotic tissue. May be reconstituted as a jelly by dissolving the contents of one vial into 5ml of sterile water and mixing the resulting solution with 15ml of Intrasite gel. Apply dressings once or twice daily; cover with a secondary dressing (Ruffer and Hill, 2001).

Sodium Chloride e.g. 0.9% solution

Ideal for topical irrigation and cleansing of wounds. Has no antiseptic properties, but on irrigation dilutes the concentrations of bacteria in the wound

Tap Water

Acceptable alternative for the cleansing of acute traumatic soft-tissue wounds and chronic wounds such as leg ulcers. Used to irrigate and clean wounds. Has no antiseptic properties. Has no detrimental effects on healing. Open wounds should only be soaked in water for a short period of time as water is hypotonic and causes cells within tissues to swell and eventually rupture because of the effect of osmotic pressure. Ensure the water comes from a properly treated supply and is lukewarm. Run tap water for a few minutes before wound cleansing to flush out any potentially high levels of bacteria. Emollients may be added to lukewarm water to moisturise the skin

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RECOMMENDED WOUND CLEANSING SOLUTIONS

For wounds not grossly contaminated, non infected or covered with necrotic tissue;

Agent of Choice = Sodium Chloride 0.9% for irrigation

For contaminated, infected wounds:

Agent of choice = Tap water eg bathing and showering

At Consultant's request only, other solutions may be used and potential adverse affects must be considered.

RECOMMENDED WOUND CLEANSING SOLUTIONS			
Cleansing agent	ADVANTAGES	DISADVANTAGES	COMMENTS
Sodium chloride 0.9% (eg Normasol)	Safe, non-irritant. Isotonic to body fluids. Single use sachets.)	Has no antiseptic qualities.	Ineffective against infection. Warm to body temperature if large area.
Chlorhexidine Gluconate 0.05% w/v (e.g. Unisept)	Wide range of Gram+ve and Gram-ve activity Relatively free from toxicity and low potential for skin irritation. Maintains antiseptic effect in presence of blood and pus.	Skin sensitivity may occur	Satisfactory antimicrobial for all types of wounds at all stages of healing. Avoid contact with eyes, middle ear, brain or meninges Do not use alcoholic preparations
Chlorhexidine gluconate 0.015% and cetrimide 0.15%	Wide range of bactericidal and fungicidal activity. Cleansing of contaminated, traumatic and infected wounds	Cetrimide toxic to wound tissues at low concentrations. Skin irritation and occasional sensitisation	Not recommended for regular wound cleansing. Contraindicated if previous sensitivity to cetrimide.
Povidone- iodine 10% (bottle must be single-patient use only)	Wide range of bactericidal and fungicidal activity. Rapid but transient action Does not cause permanent staining of skin or clothing Low incidence of skin reactions	Action reduced by contact with pus and exudate. Not for prolonged use in severe burns, pregnant or lactating women. Not for regular use in neonates and contraindicated in very low birth weight infants. (<1500 grams). Regular use is contra-indicated in thyroid disorders	Satisfactory antimicrobial in aqueous form (non-alcoholic) for all types of wounds at all stages of healing. Can be diluted for use as an irrigation solution. Wash off excess solution before using occlusive dressings

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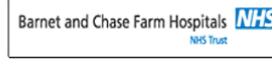
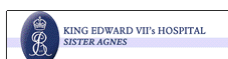
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