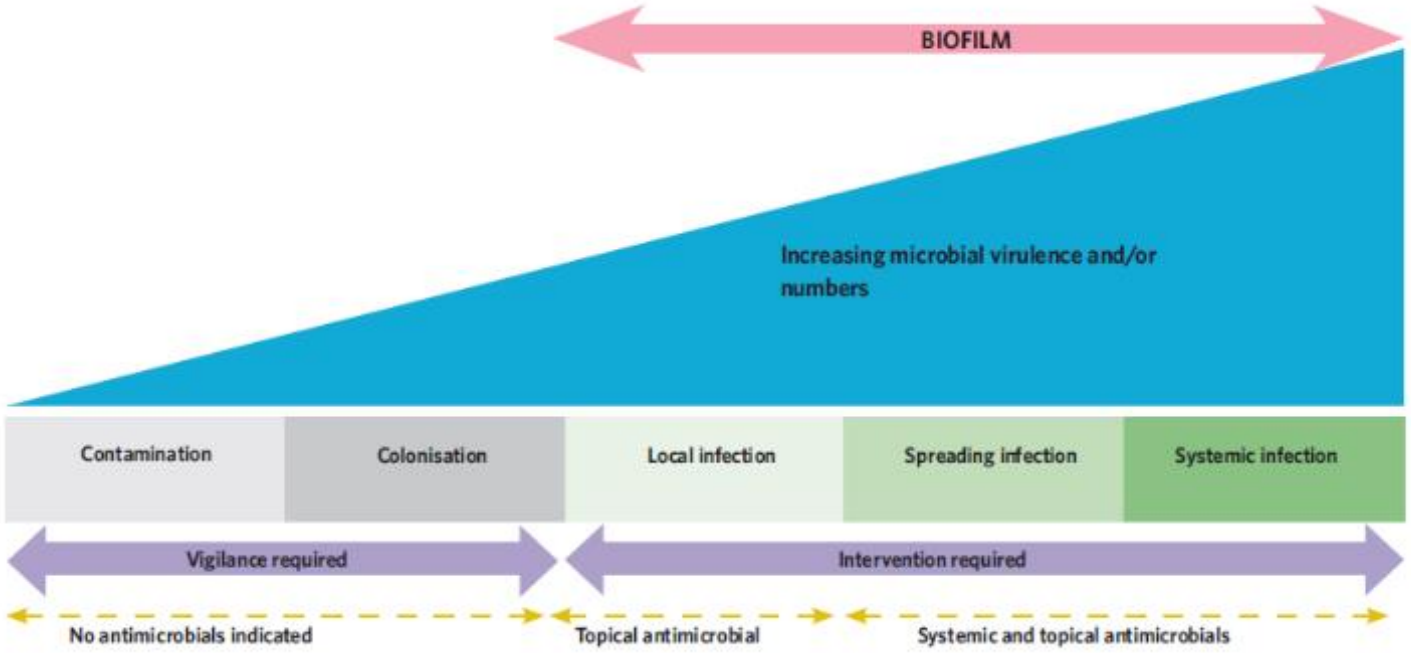
TIME

Assessment
I – Inflammation/Infection

➢ Wound Infection Continuum



INTERNATIONAL CONSENSUS UPDATE 2016

INTERNATIONAL WOUND INFECTION INSTITUTE

WOUND INFECTION IN CLINICAL PRACTICE

Principles of best practice

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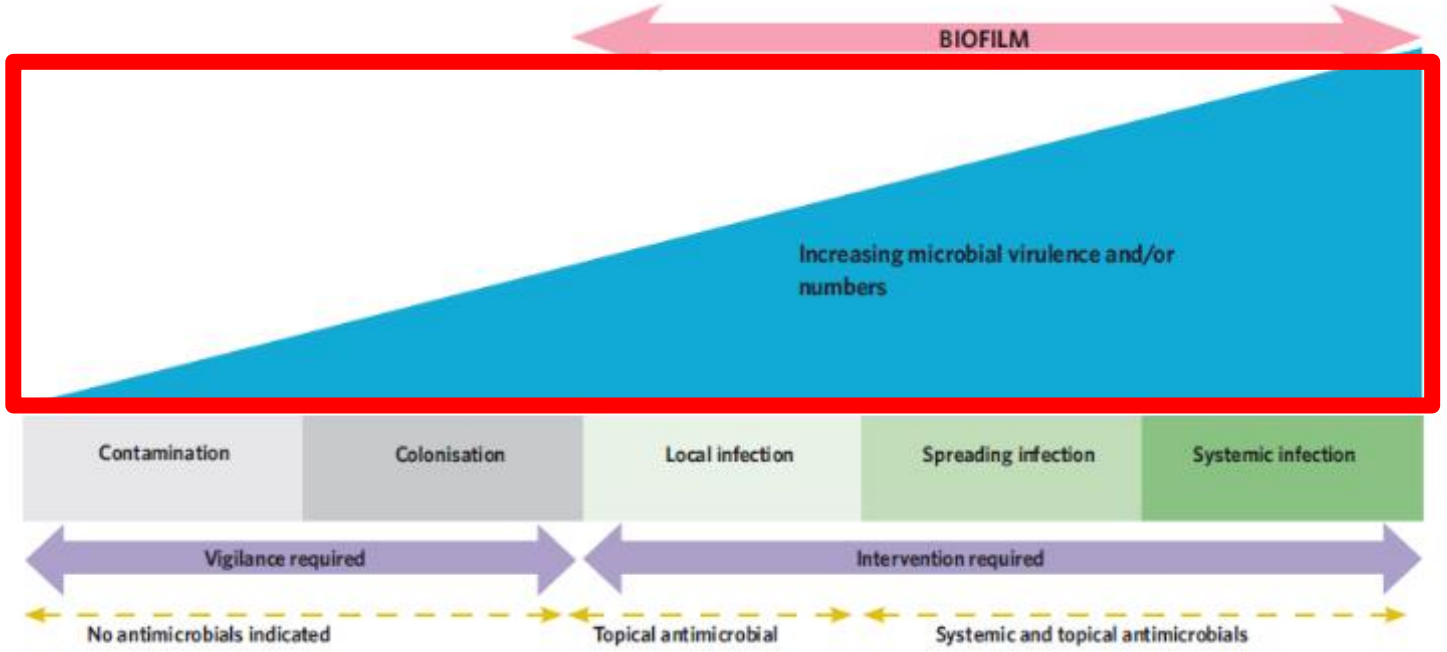

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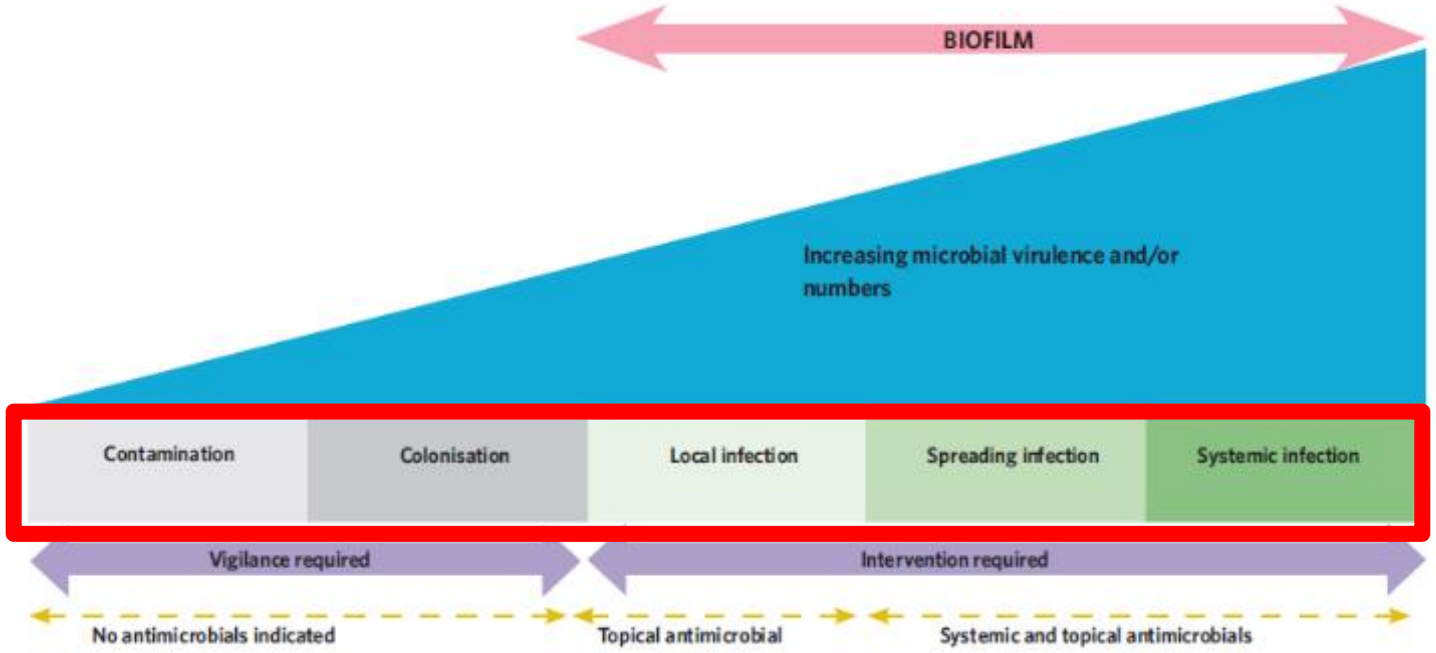

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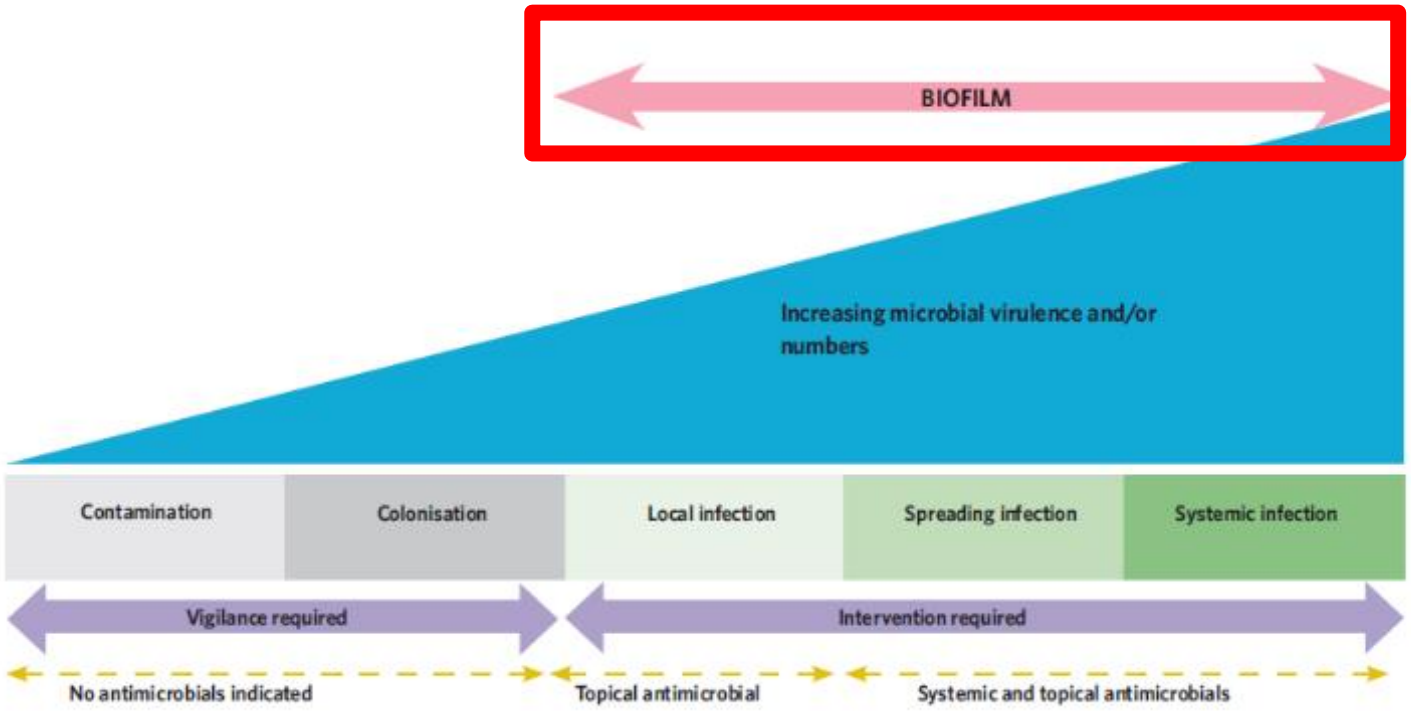

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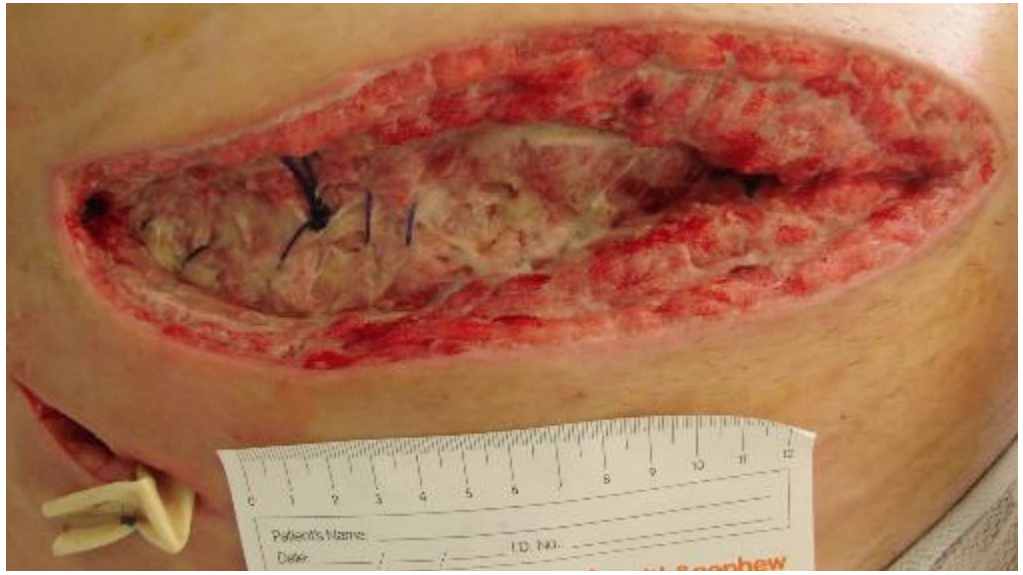

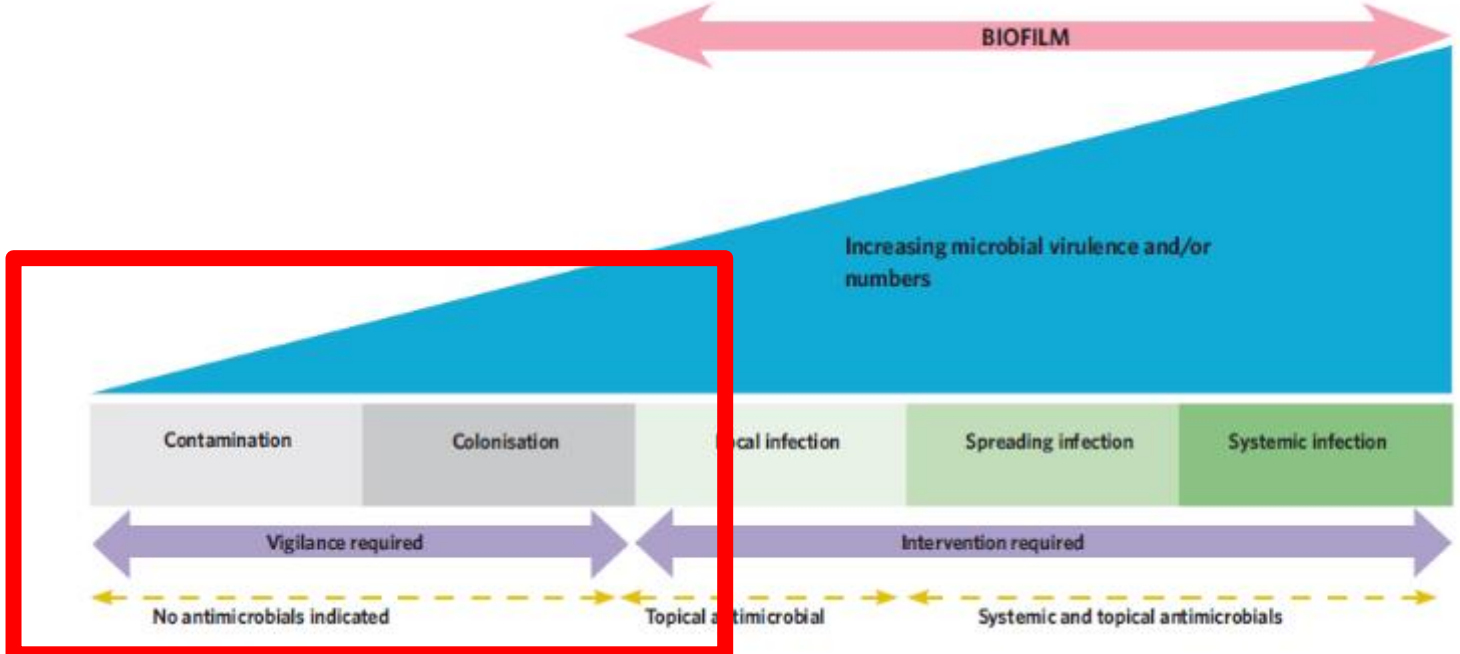

Wound Infection Continuum

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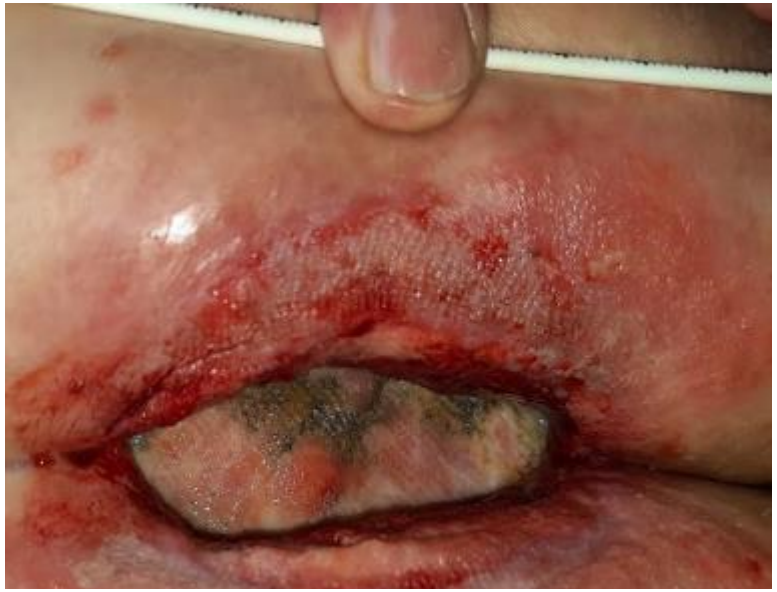

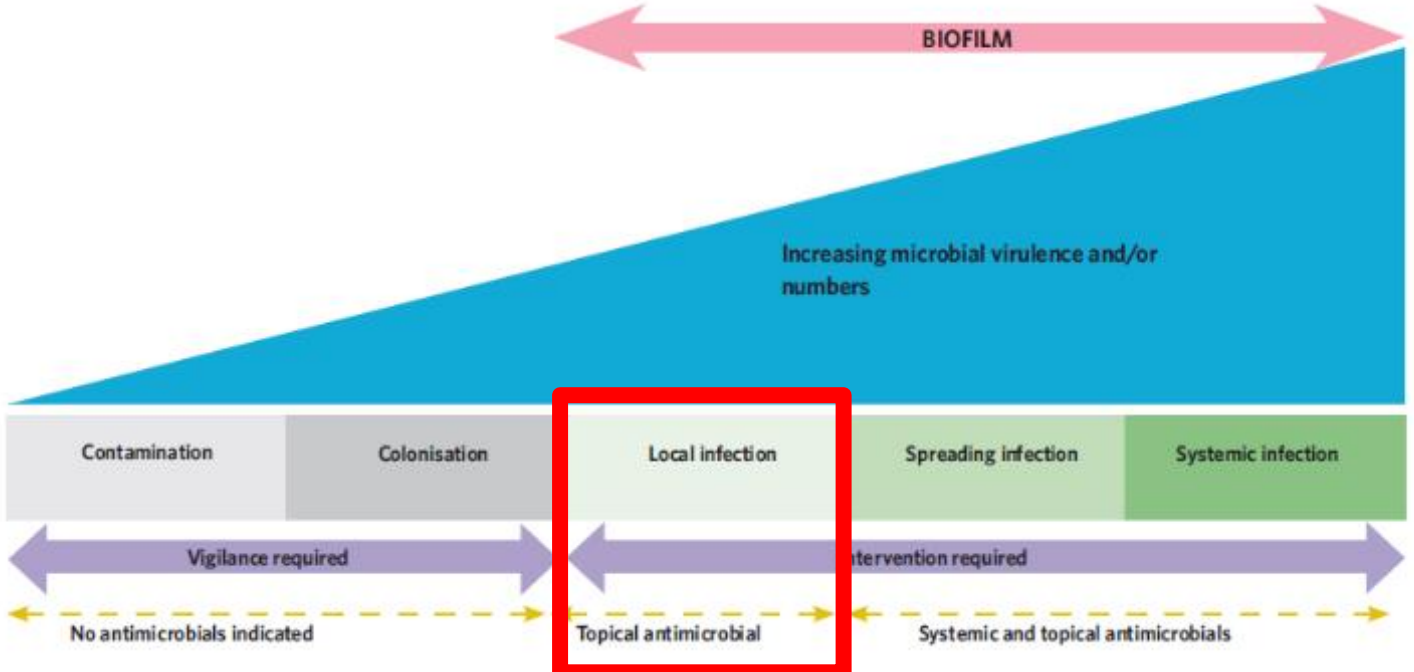

Wound Infection Continuum

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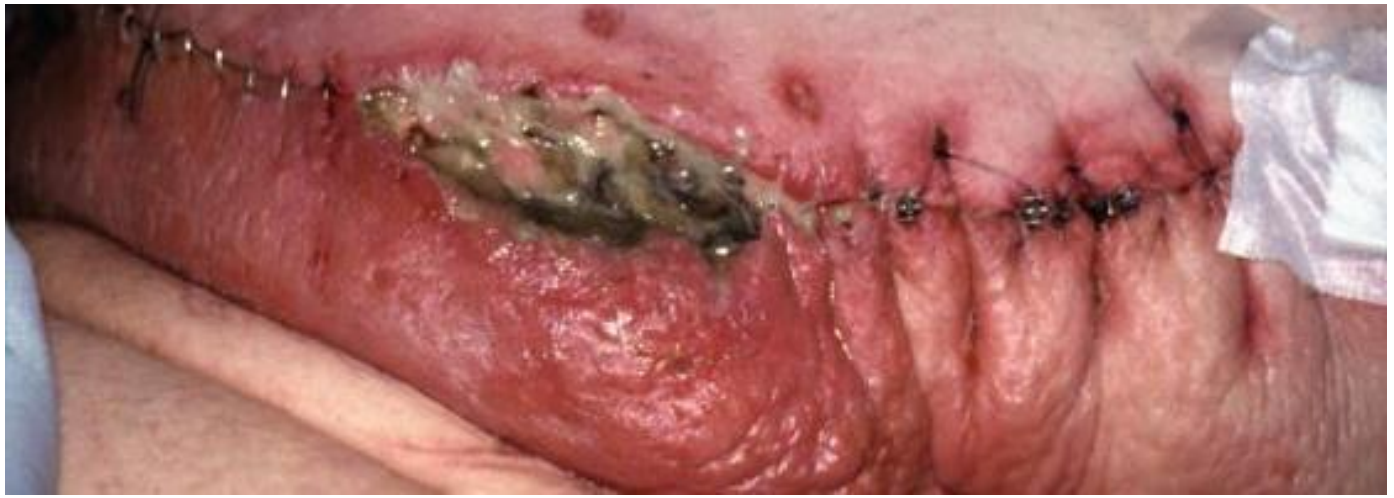
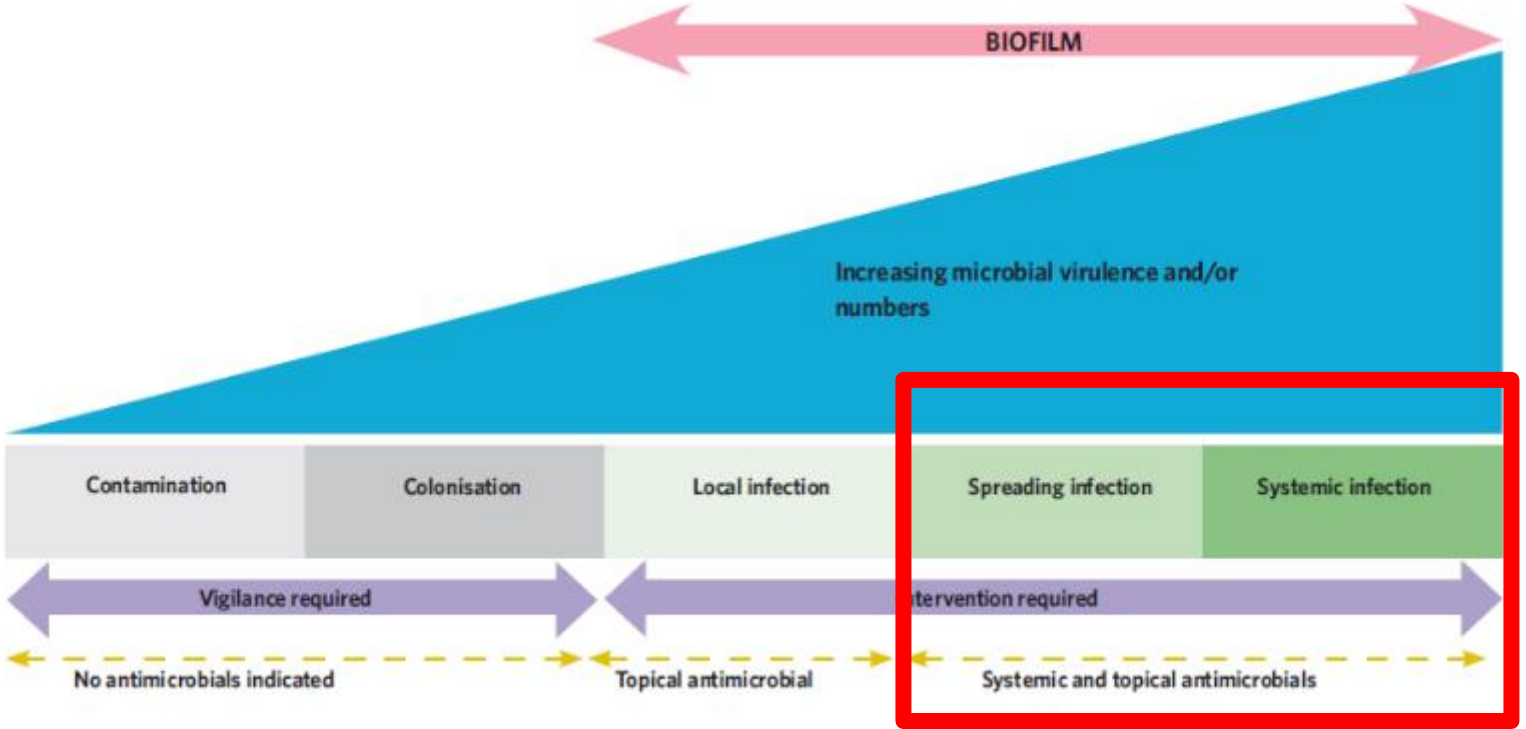
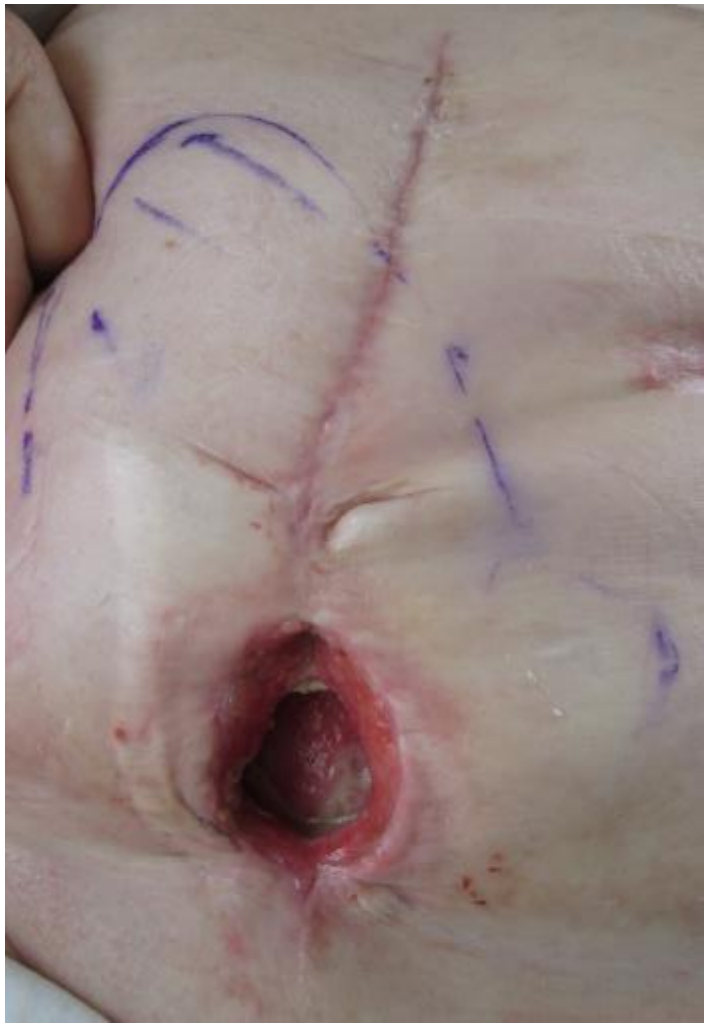




M- Moisture Balance
Exudate Type and Level

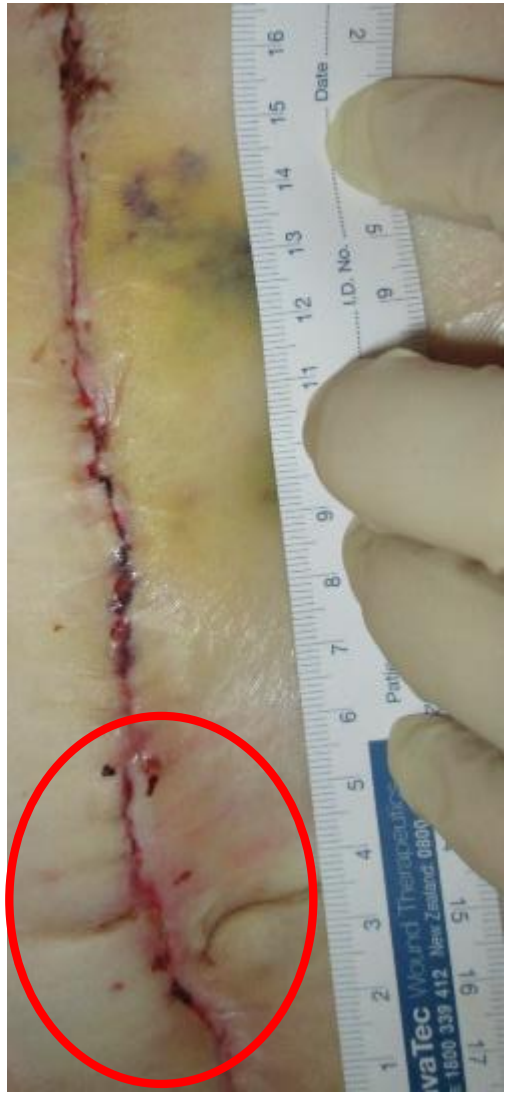
TIME

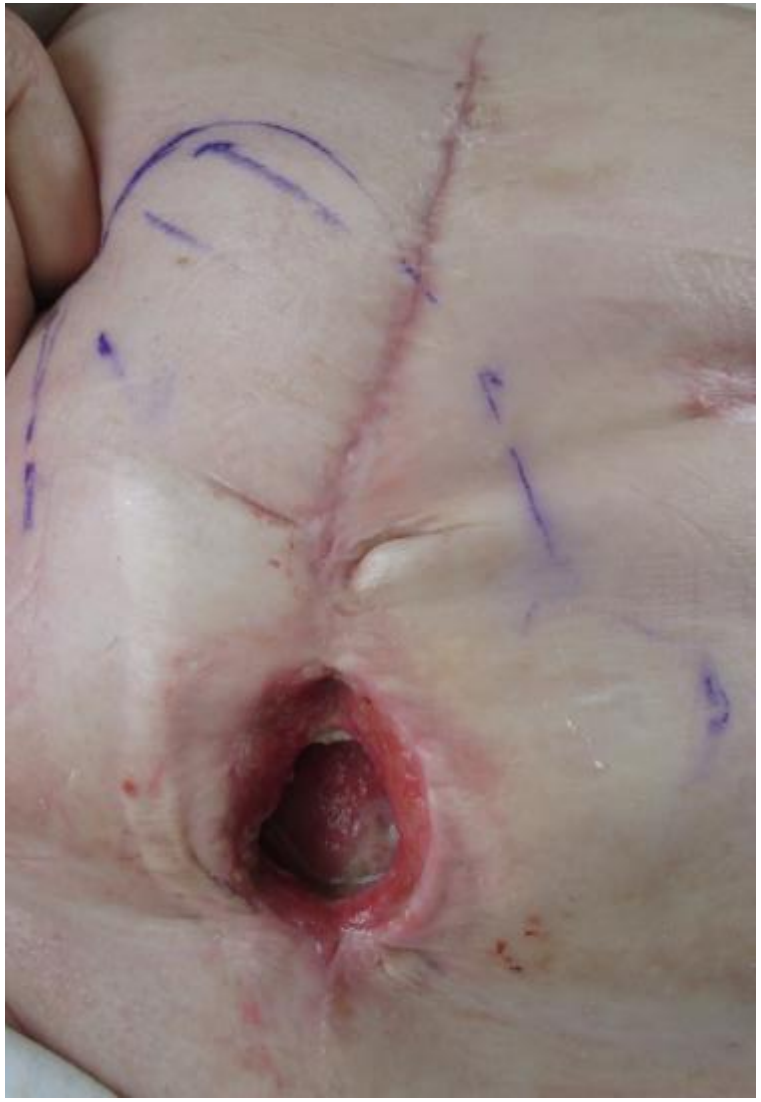
Assess	Specifics
Exudate colour, consistency, type and odour	Purulent (cream or green) Haemopurulent (red, brown) may indicate infection Yellow or brown - may indicate a urinary or enteric fistula Malodour - may indicate infection or fistula
Exudate level	Condition of the current dressing Frequency of dressing dry dressing indicates low exudate levels leaking dressing indicates higher level

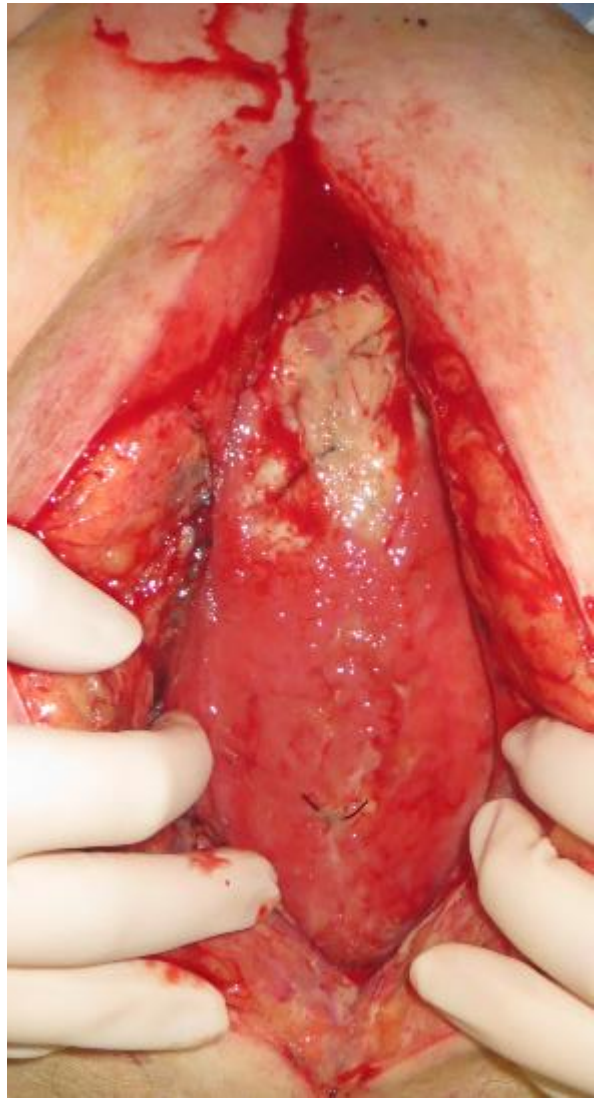


Assessment
M- Moisture Balance

TIME







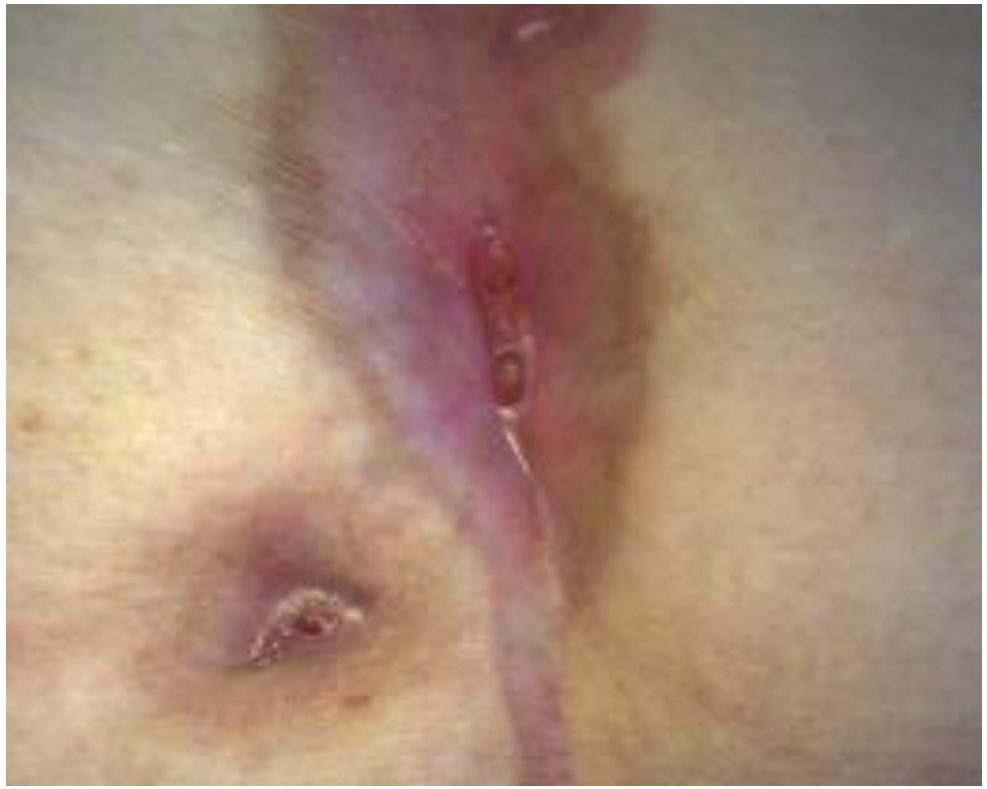
E – Edge
Surrounding Skin

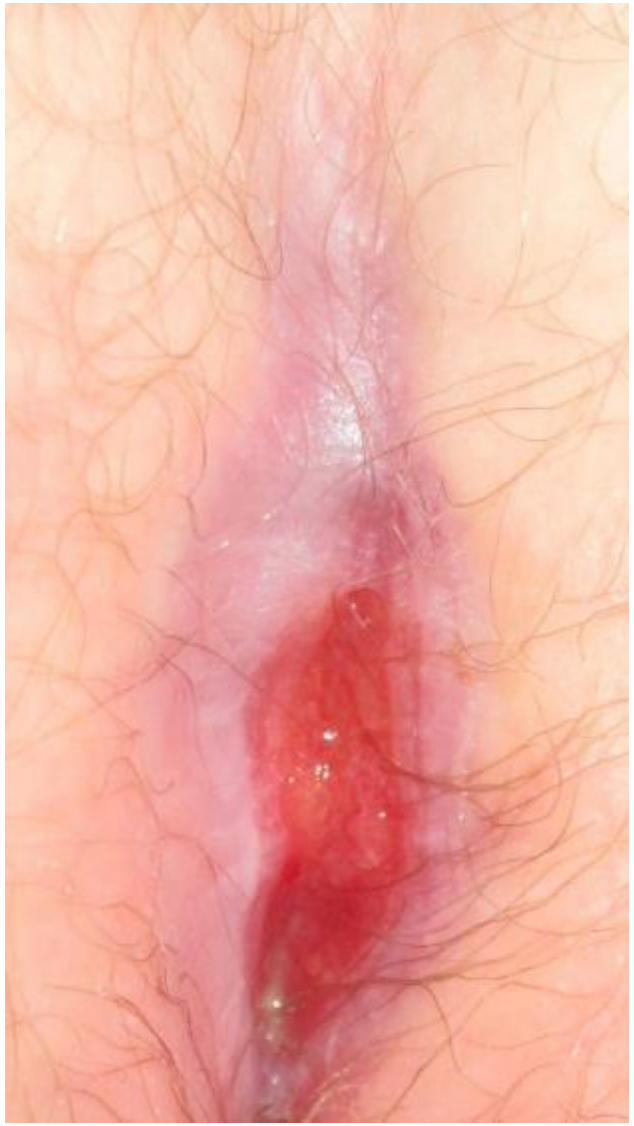
TIME

Assess	Specifics
Edges of dehisced area	In long-standing areas of dehiscence, the edges may become undermined
Colour and condition of the surrounding skin	Dermatological conditions that may affect healing e.g. radiation dermatitis Signs of spreading infection e.g. spreading erythema, warmth and oedema Periwound maceration may indicate high exudate/drainage levels and/or inadequate absorbency of the dressing

Assessment
E – Edge

- Advancing Edge = Healthy wounds
- Contraction of the wound





Management of SWD
Working Together

Healing SWD requires Team Work

- Patient
- Relatives
- Physiotherapist
- Receptionist
- Surgeons
- Occupational therapist
- Hospital Nurses
- Community nurses
- Care givers
- Wound care specialist
- Health care assistants
- Nutritionist
- Social worker and others

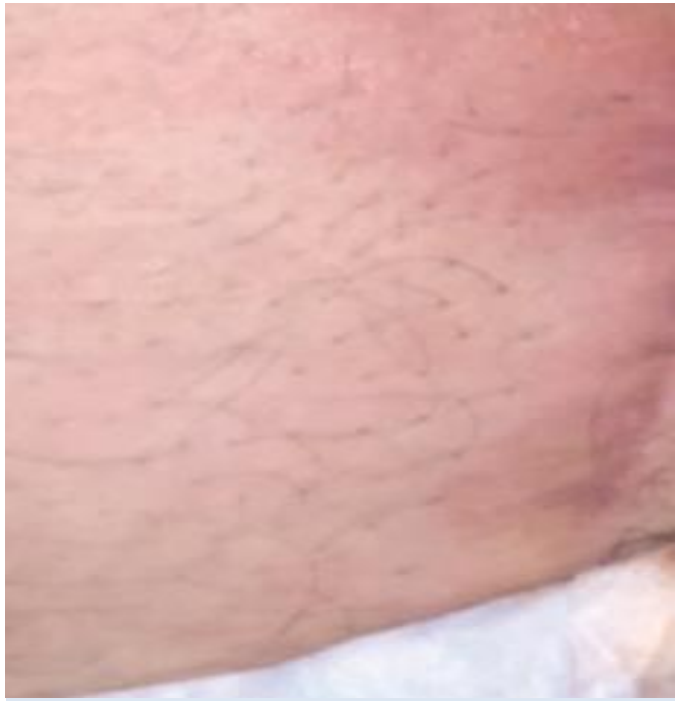
Management of SWD

Principles of Management of SWD

- Reassurance, Management of expectations and education
- Pain Management
- Removal or adjustment of risk factors
- Management of systemic infection
- Management of local infection
- Management of the dehisced wound

Management of SWD

- Drain abscess, seroma or haematoma as appropriate

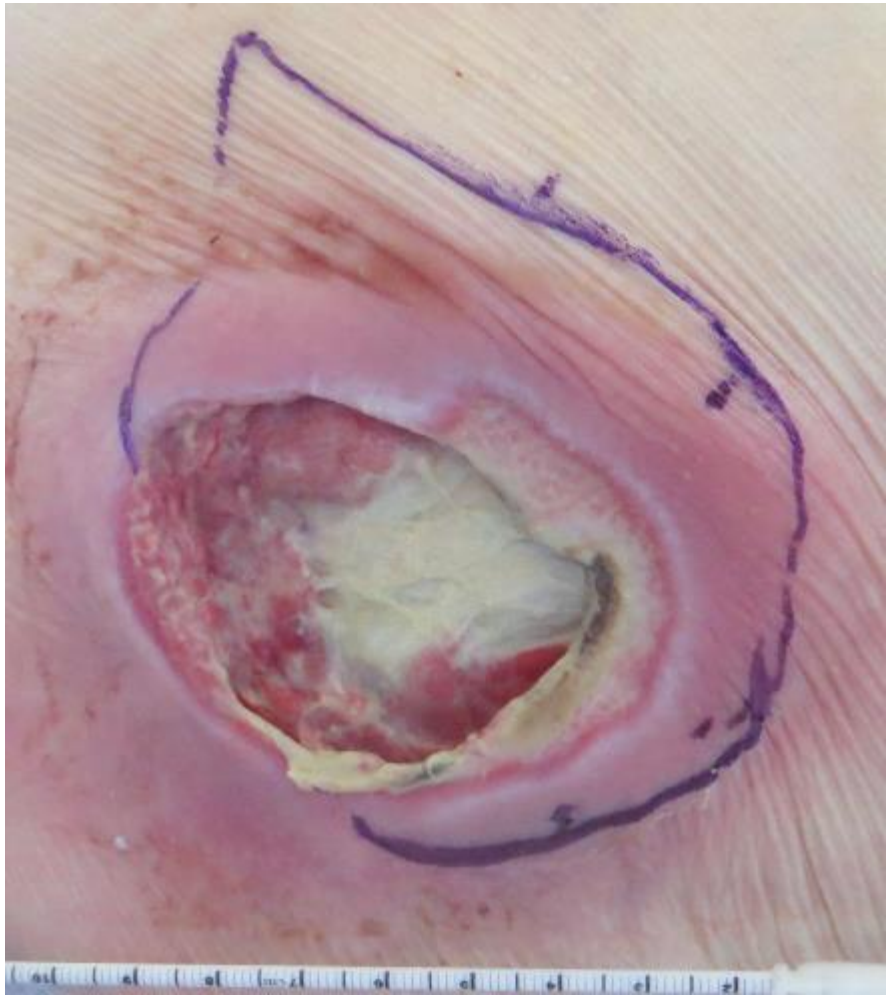


Abscess under an
abdominal incision draining

Management of Systemic Infection

Use systemic antibiotics in adults if there is
✓Clinical evidence of systemic sepsis
✓Spreading cellulitis

Do not use systemic antibiotics
Specifically to heal SWD
Based only on positive wound cultures
without clinical evidence of infection

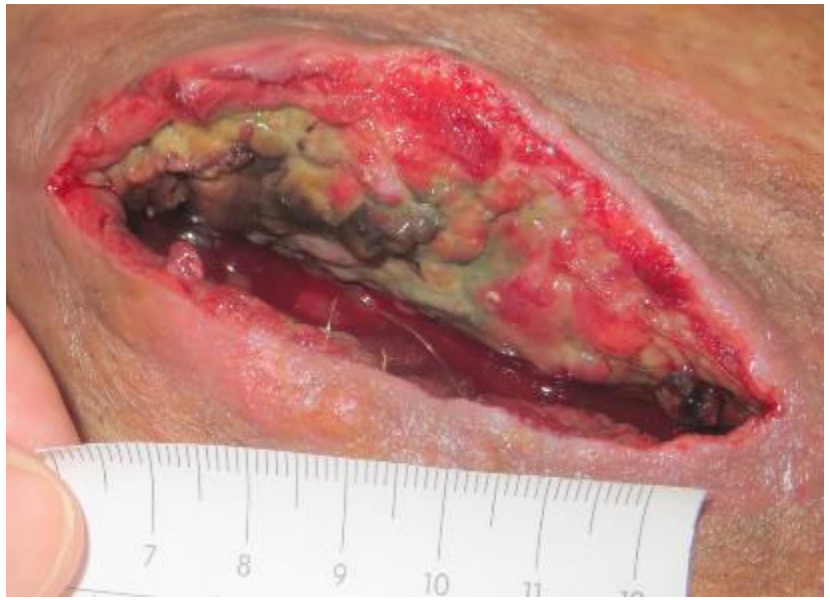


Management Local infection

Control bacterial bioburden

Antiseptics commonly used:

- ✓ Iodine compounds (cadexomer iodine)
- ✓ Silver compounds
- ✓ Polyhexanide and betaine (PHMB)
- ✓ Chlorhexidine Cetrimide
- ✓ Acetic acid (dilute)
- ✓ Honey

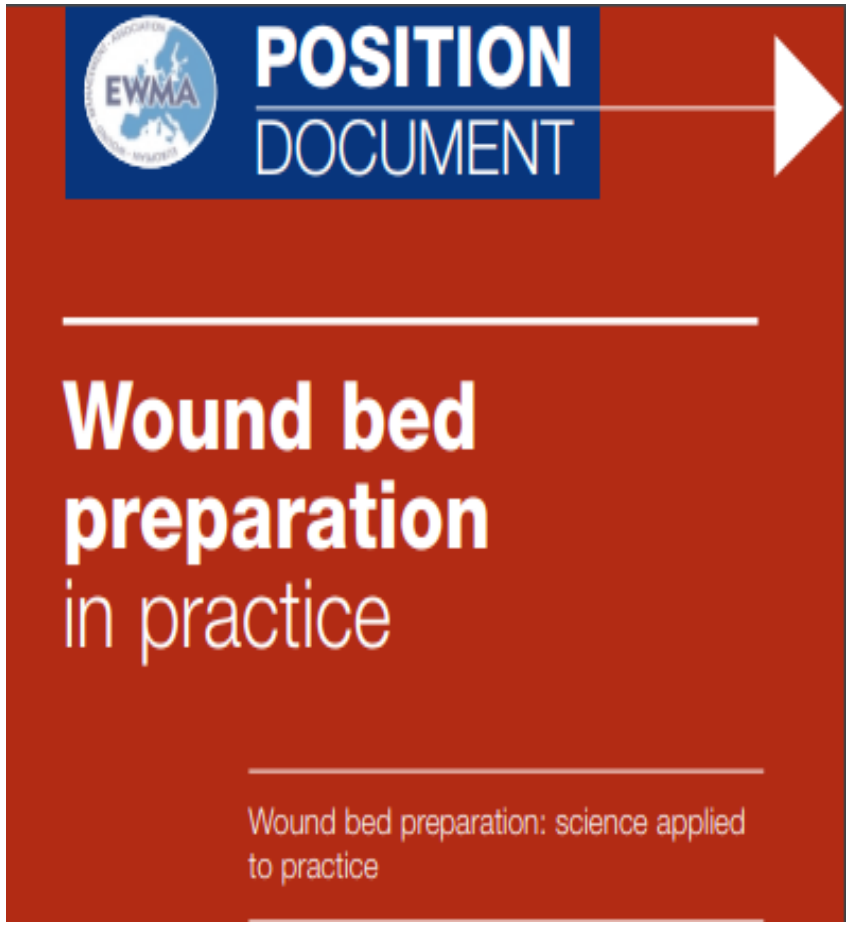


Do not routinely use topical antiseptics or antimicrobials

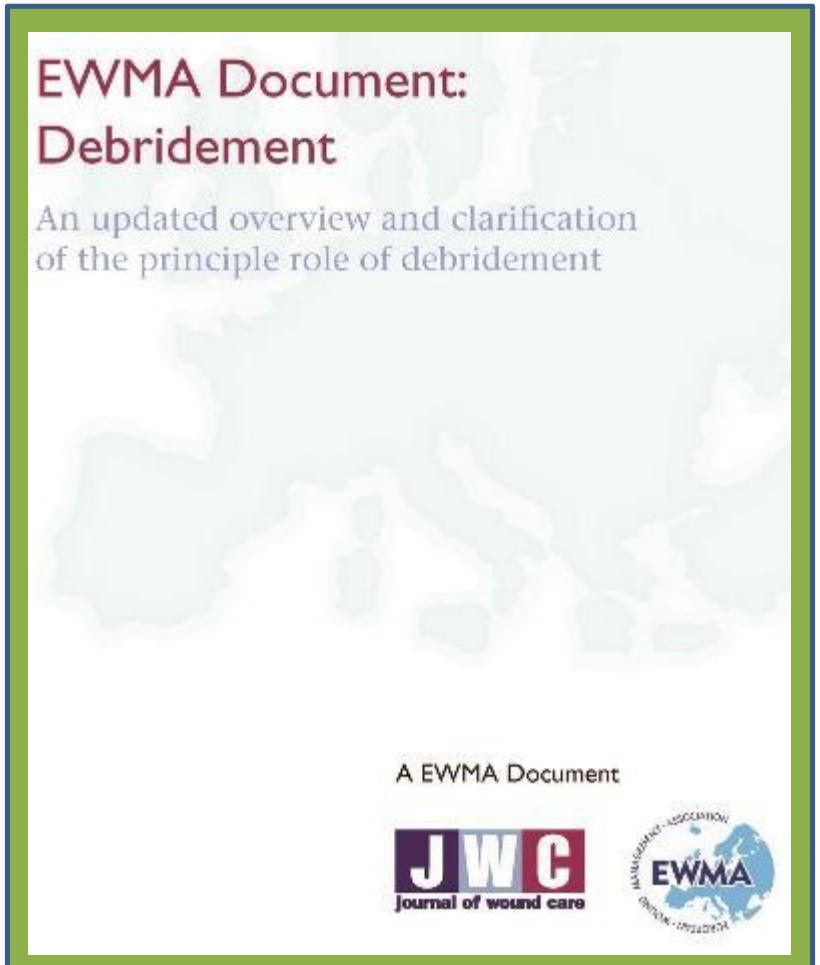
Use for a limited time e.g. 2 week challenge

Wound Bed Preparation + Debridement

- A systematic approach to wound management by identifying and removing barriers to healing



- Debridement

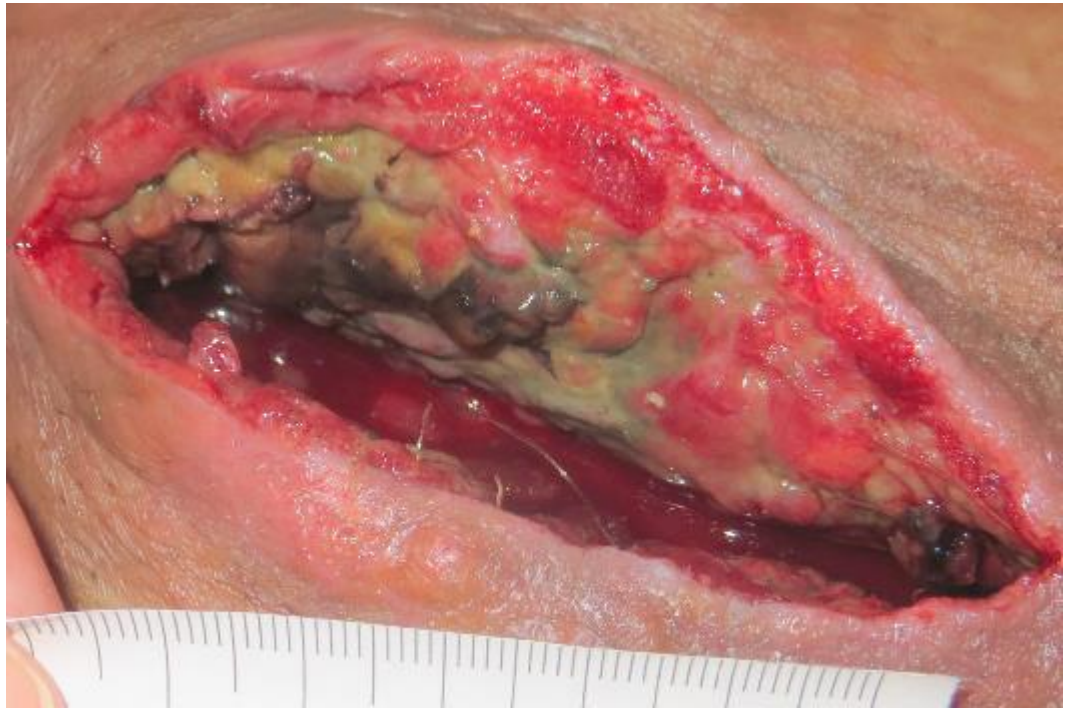


Wound Bed Preparation
Wound Cleansing

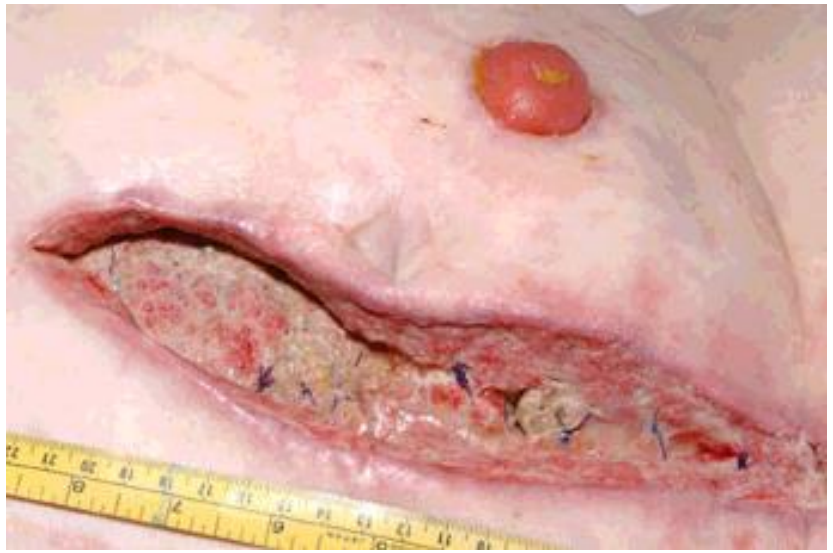
- ➢ Cleanse according to local policies
- ✓ Cleanse at each dressing change
- ✓ Use cleansing solutions with surfactants and/or antimicrobials in wounds with high levels of bacterial colonization(Malodour)

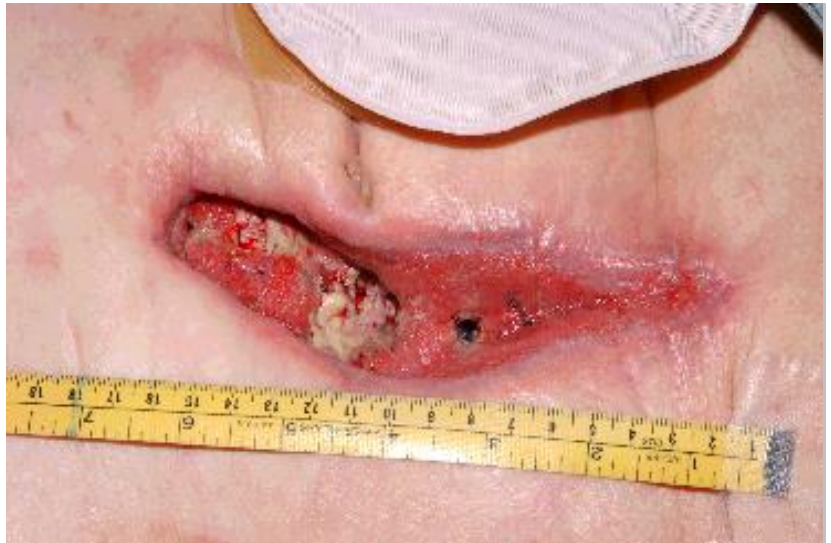
Wound Bed Preparation
Debridement

- Debride non-viable or necrotic tissue, using an appropriate method within the skill set of the clinician
  - ✓Autolytic (hydrogels)
  - ✓Enzymatic (Kiwi fruit, Papaya)
  - ✓Biological (larval)
  - ✓Mechanical (ultrasound, hydro surgical)
  - ✓Surgical (usually in Theatre)



Wound Bed Preparation
Set Intermittent Goals



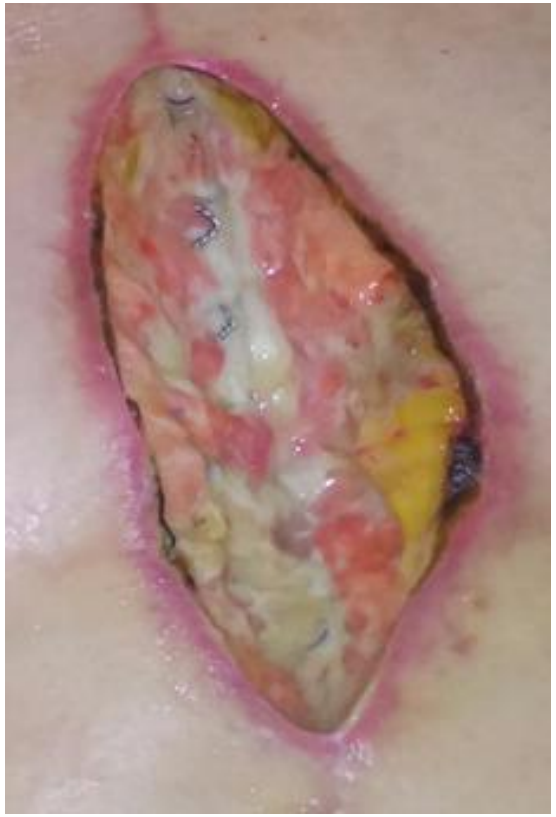


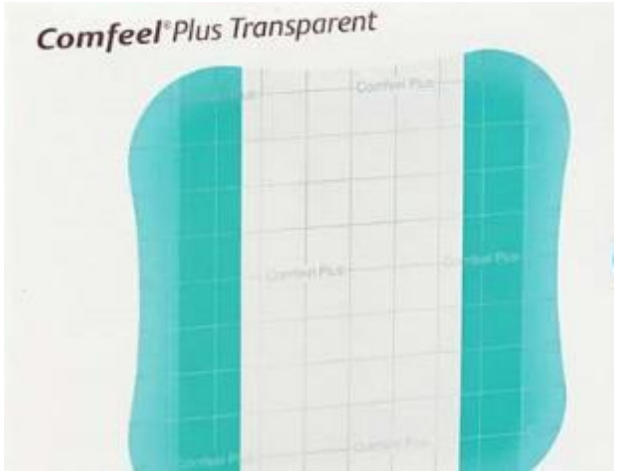
- Hydrogels
- Cadexomer Iodine
- NPWT

Protect the Surrounding Skin

Keep Surrounding Skin Healthy and Intact

- Many Good Skin Barrier Products
- Use Adhesive Remover
- Reduce Pain

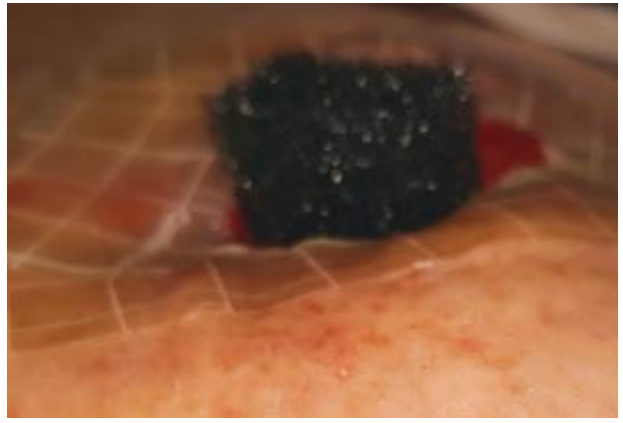


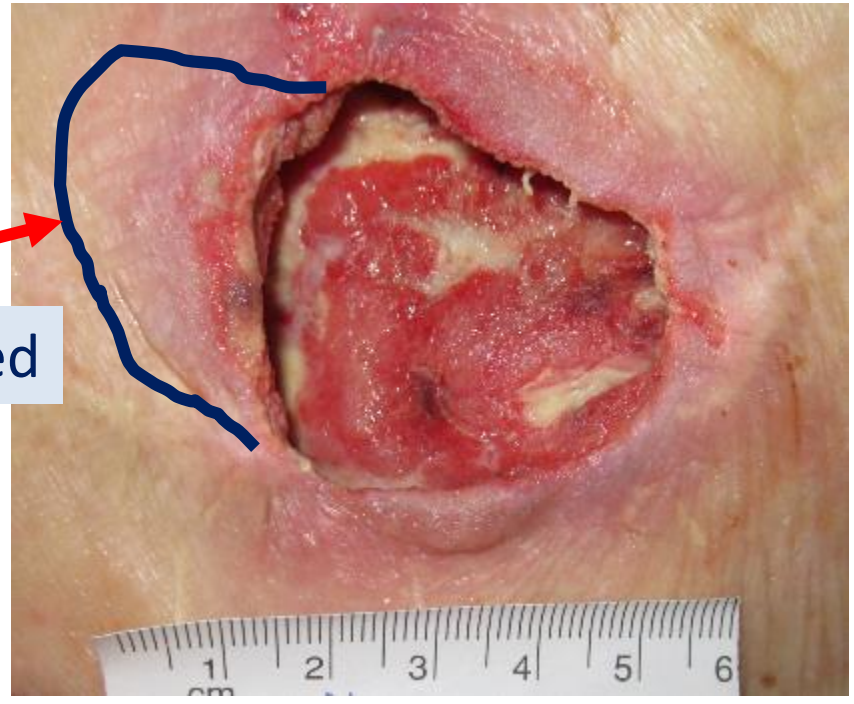


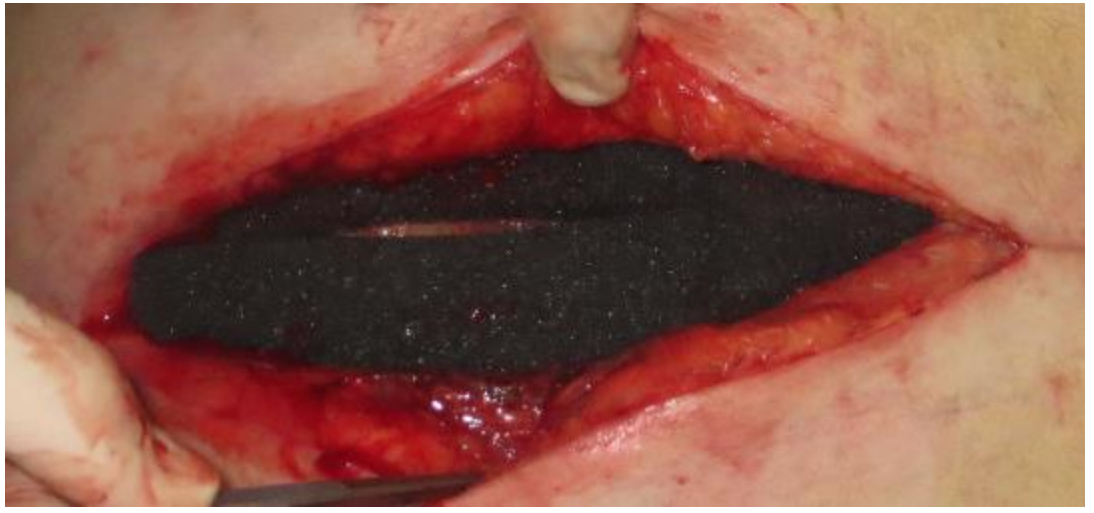
Wound Dressings for SWD

Principles:

- ✓ Cavity, undermined tissue or tracks must be filled with a wound filler
- ✓ Extend Wound filler 3 cm so its visible
- ✓ Count the number of dressings and document clearly
- ✓ **What goes into the wound must come out again!**
- ✓ **Always be aware of the risk of retained dressing**







Types Wound Fillers

Common Wound Fillers:

- Calcium Alginates
- Gelling Fibres
- Foam
- Gauze

Refer To Local Wound Product Guide

Wound Product Practice Guideline (District)

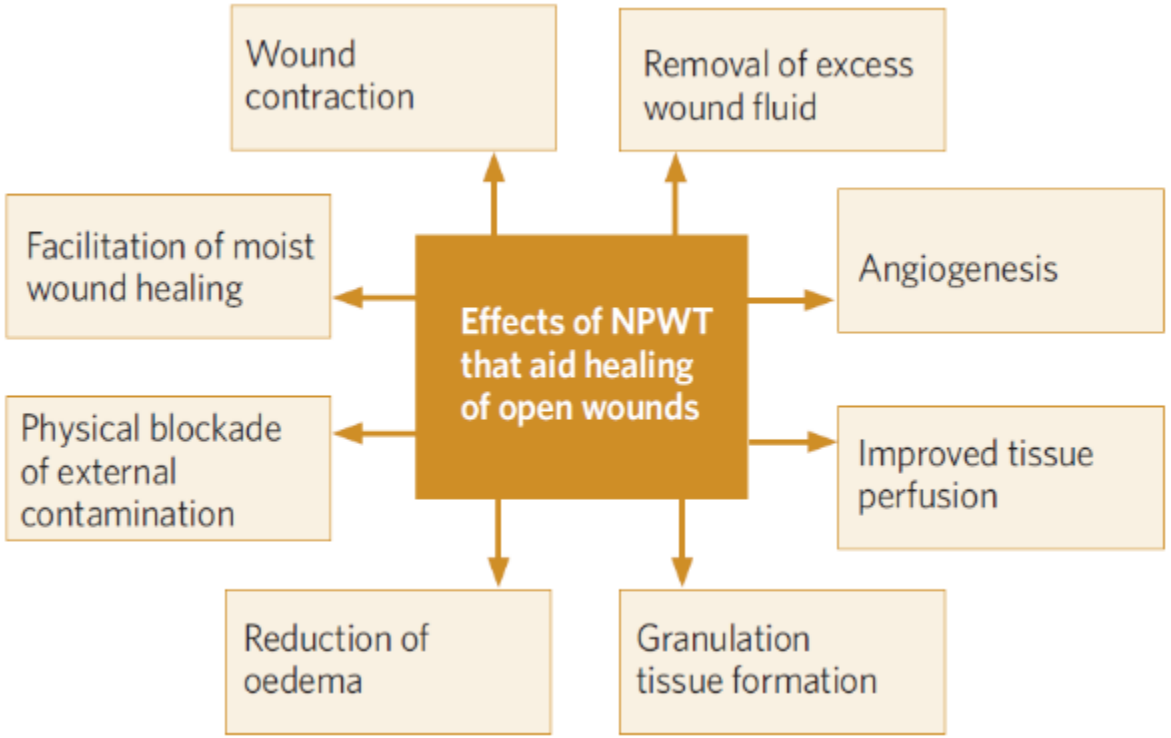
Cost Guide: GREEN: Go! Continually monitor wound progress.
Cost Guide: ORANGE: Consider! Dressing must stay *in situ* 3 to 7days (unless otherwise indicated); if not choose a more cost-effective option.
Cost Guide: RED: Stop! Dressing must stay *in situ* 5 to 7days (unless otherwise indicated); if not choose a more cost-effective option.

Depending on exudate levels most products can be left up to 7 days unless stated otherwise.				
Primary Product	**Function**	**Secondary Dressing e.g.**	**Wound Indication**	**Practice Tips**
Low Adherent Mesh (no absorbency)				
Cutiderin	Low-adherent	gauze, combine or mesorb	Flat wound, finger/hand wounds	Cut slits in dressing to allow passage of viscous exudate; do not overlap or use under foam or hydrocolloid dressings. For finger injuries cut slits down the side to allow finger to bend.
Open Pore- Silicone (no absorbency)				
Mepitel	Non-adherent; anchors onto skin, secure skin tears	gauze, combine or mesorb	Painful and/or flat wounds e.g. skin tears and finger-injuries.	Moisten gloves with sterile water or saline to avoid sticking to gloves; do not overlap. Can be left up to 14 days (but change secondary dressing) in non-infected wound or if dressing pores are not clogged with exudate.
Gel (donates moisture)				
Solosite & intrasite conformable	De-slough & re-hydrate	opsite, comfeel or mepilex border	Dry necrosis & dry slough	Not for wet wounds. Apply gel at 5mm thickness. Left up to 3 days. Recommend intrasite conformable dressing over exposed tendon / bone to keep moist and viable.
Film (donates moisture) - use remove wipes to remove				
Opsite or tegaderm	Waterproof, fixative	not required	As a secondary dressing to retain moisture	Not advised as a primary dressing as not absorbent. Avoid over dressings such as mesorb or foams as reduces dressing breathability and increase microbial growth.
Opsite post-op (sterile film)	Waterproof with low adherent pad	not required	Surgical post-op wounds, small cuts/grazes	Low absorbency. Do not use on infected or highly exuding wounds.
Hydrocolloid (minimal to moderate absorbency) - use remove wipes to remove				
e.g: Comfeel/Duoderm transparent & ulcer plus	Waterproof, re-hydrate & debride	not required	Transparent: low exudate & Ulcer: moderate exudate	Cover 1-2cm larger than wound. Not for infected/highly exuding wounds. AVOID USE ON SACRUM OR BUTTOCK as wrinkles increase risk of pressure injury.
Calcium-Alginate (moderate absorbency)				
Kaltostat – flat dressing or rope	Absorb, debride & haemostatic	combine, mesorb, or foam	Moderate to high exuding wounds.	Pack lightly into cavities. Can break hence do not use if dressing cannot be fully reached or removed safely.
Hydrofibre (high absorbency)				
Aquacel Extra - flat dressing or rope	Absorbent, debride	combine, mesorb, or foam	Moderate to high exuding wounds.	Pack lightly into cavities. Dressing is stitched to ensure residual dressing is not left behind; leave 2cm end out of wound cavities to allow easy removal.
Absorbent Pad (high absorbency)				
Mesorb	Absorbent with low adherent	secure with hypafix or bandage	High exuding wounds	Mesorb is more absorbent than gauze/combine and these products should not be used under Mesorb. If adheres to wound use cutiderin under mesorb.

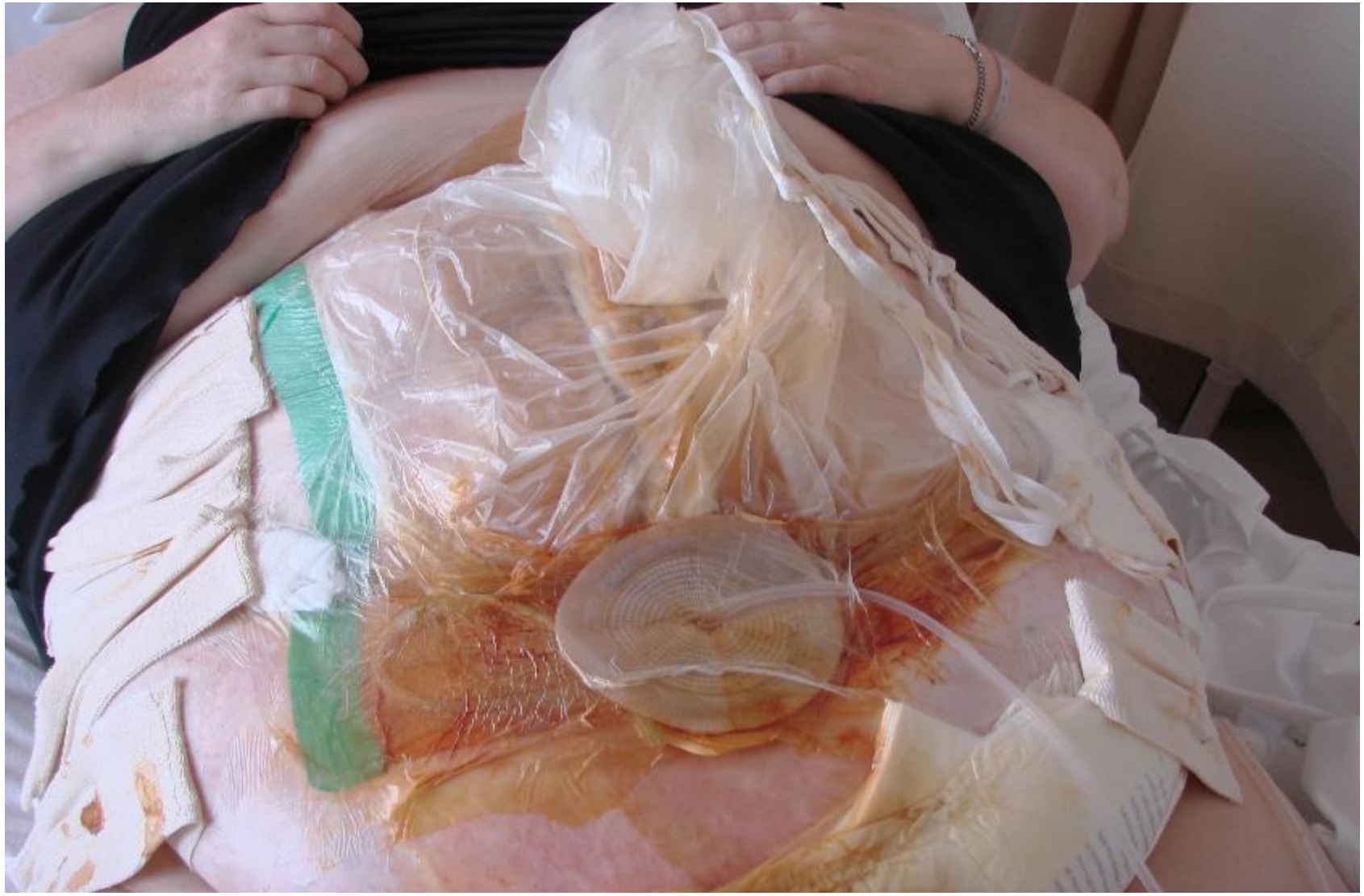
Negative Pressure Wound Therapy (NPWT)

NPWT has revolutionized SWD treatment

- Canister based systems
- Instillation Therapy
- Topical NPWT
- Disposable NPWT

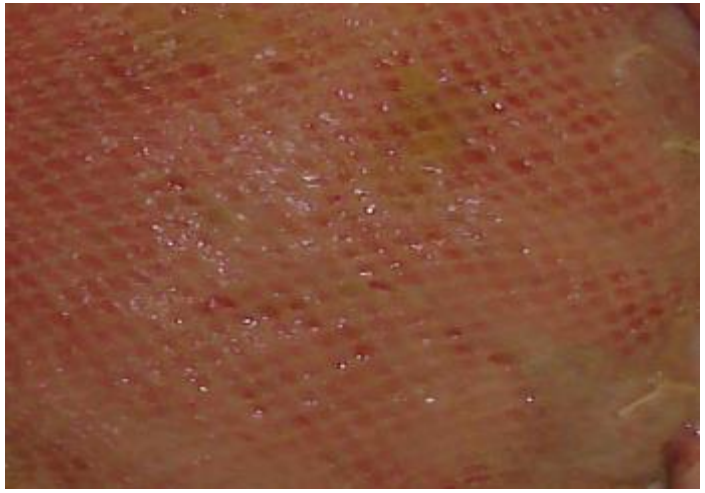


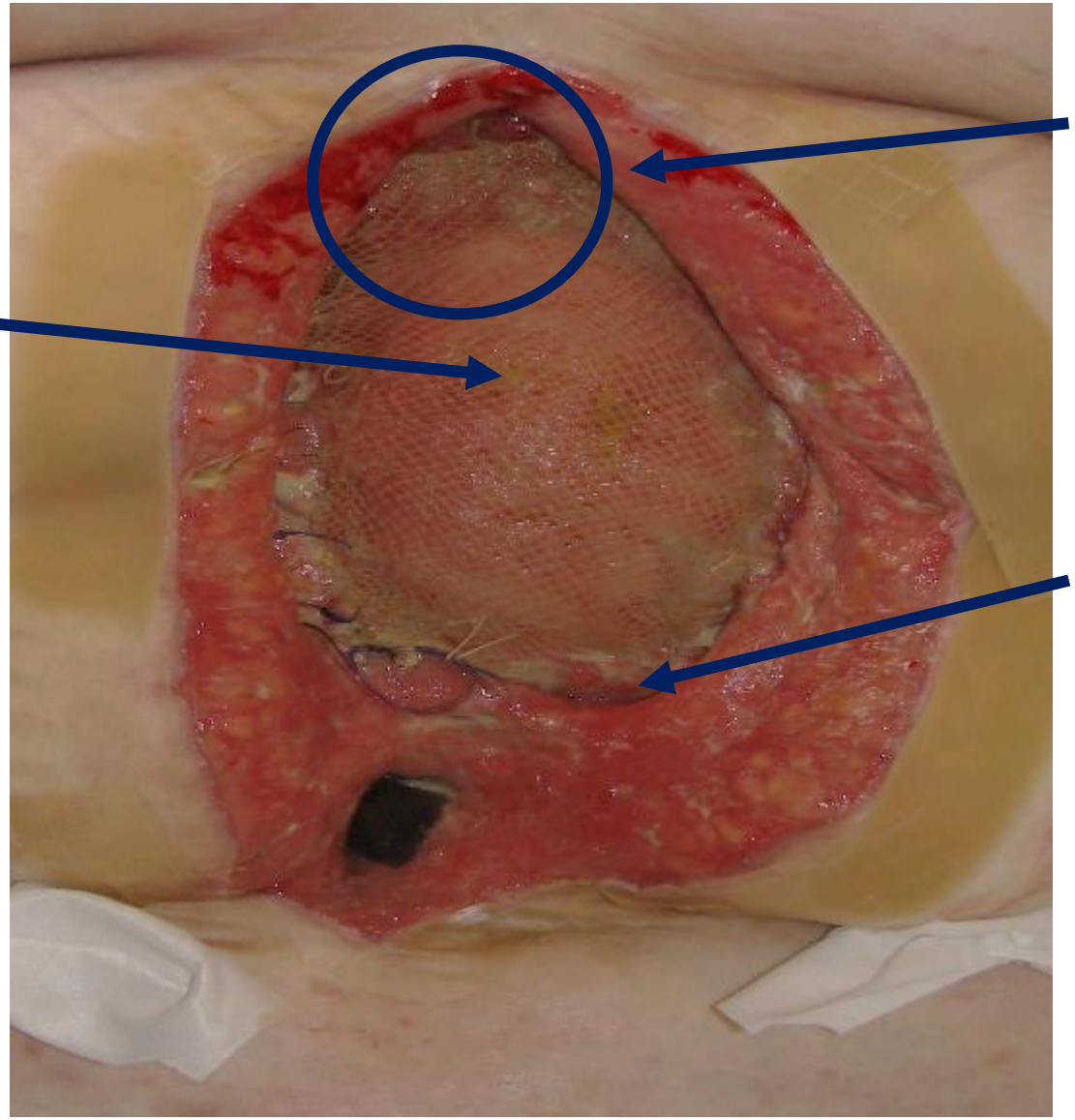
Abdominal Wound Management before NPWT



Abdominal Wound Management with NPWT

Surgical Mesh



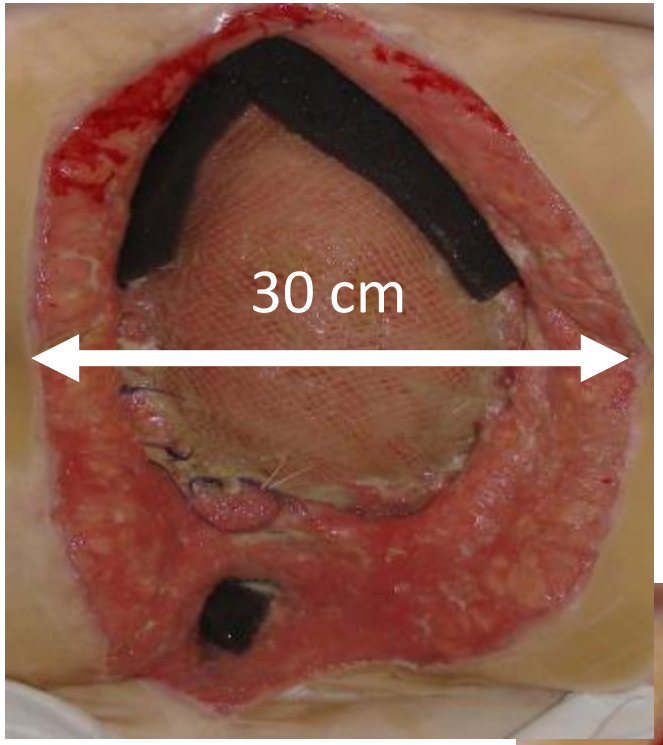


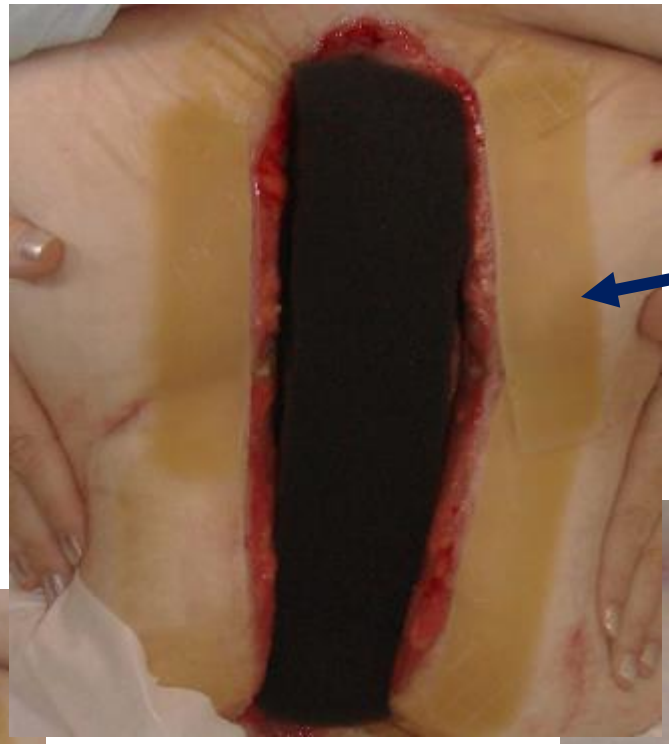
Detached Mesh

Sinus 5 cm
5 o'clock

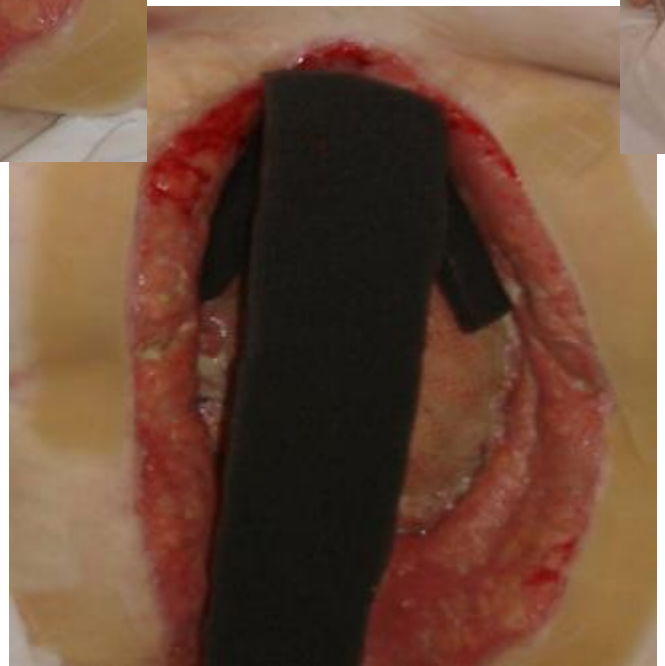
Sinus 8 cm
7 o'clock

Abdominal Wound Management with NPWT

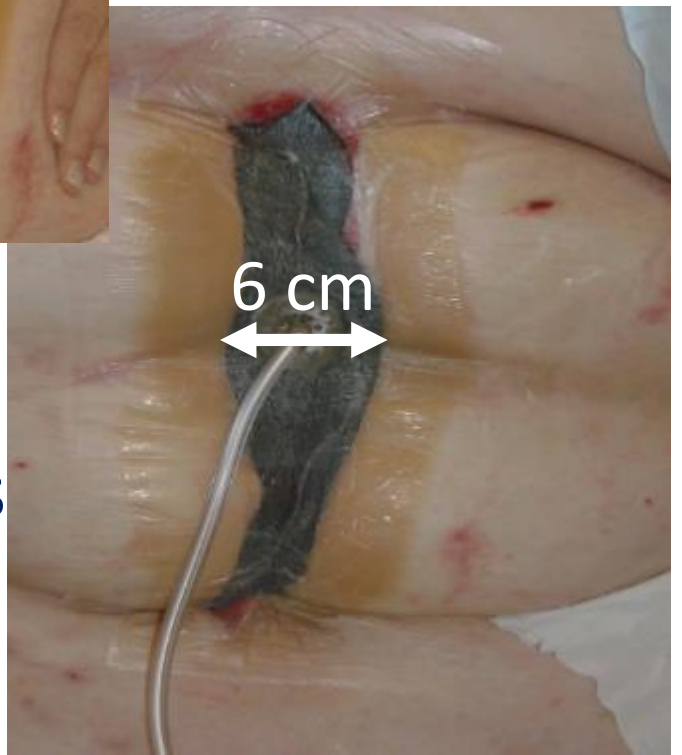




Hydrocolloid



6 Foam Pieces



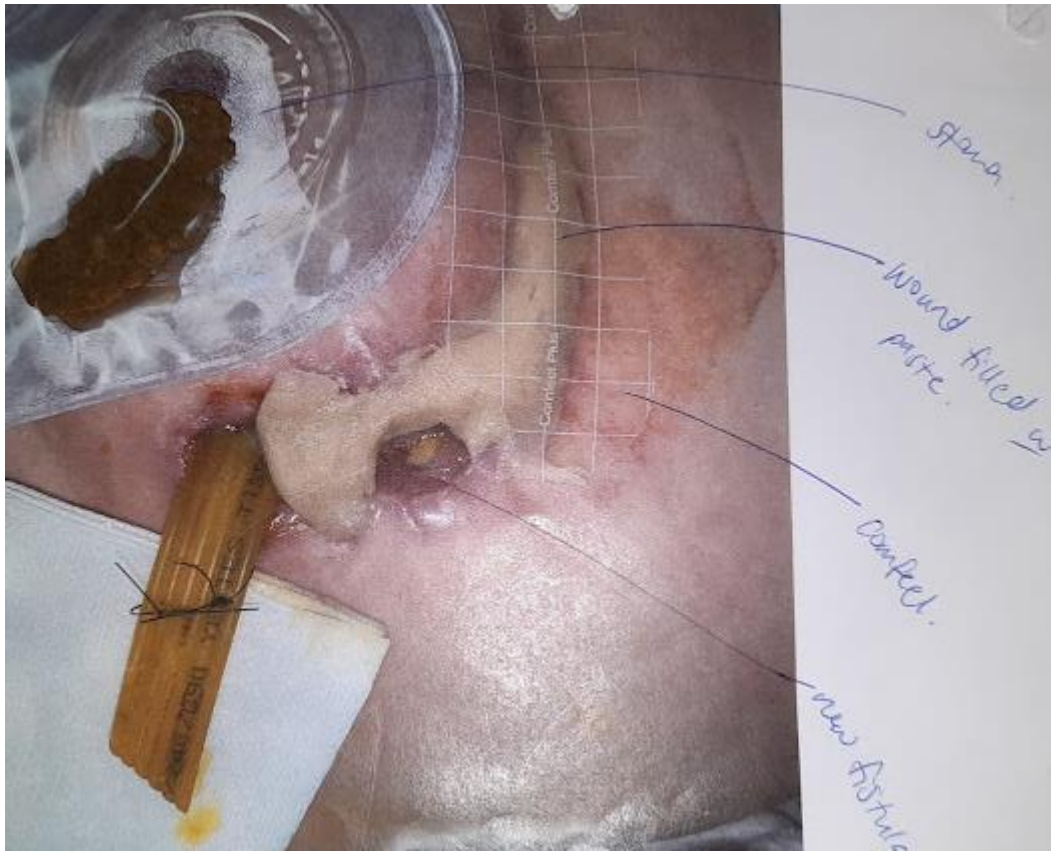
Adjunct Therapy

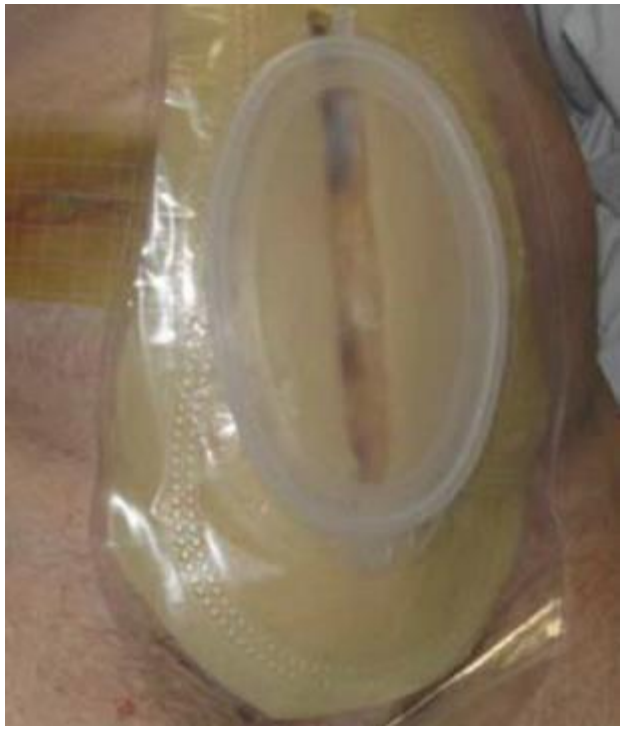
Physical Splinting

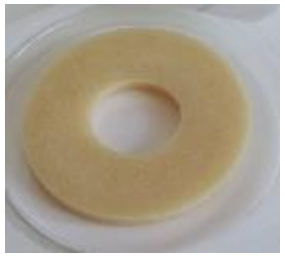
- Use Pillow when Coughing or straining
- Use Abdominal Support binders!

Abdominal Wounds with Fistulae

- NPWT
- Wound and Stomal Therapy
- Protect surrounding Skin
- Pain Management
- Individualize Treatment plan








THANKS
FOR
WATCHING

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