

Assessing and Managing Chronic Wounds

Wound Care Reference Guide

*For health care professionals
who want to increase their basic knowledge
on chronic wound management*

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Wound Care Mini Glossary

Bacteria	Single cell organisms that can damage healthy cells / tissues.
Bacterial load	The total number of bacteria in a wound; they may or may not be causing a host response.
Colonisation	The presence of replicating bacteria that adhere to the wound bed but do not cause cellular damage to the host.
Critical colonisation / Local infection	An increasing bacterial load on a wound that is between the category of colonisation and infection. The wound does not heal but may not display classic signs of infection.
Emollients	Emollients (moisturisers) prevent the skin from becoming dry. Emollients can be applied as often as needed.
Epithelialization	The process of the formation of new epithelial tissue – the upper layer of the skin.
Granulation tissue	The pink to red, moist, fragile capillary tissue that fills in an open wound bed during the proliferative (cell division) phase of healing.
Infection	The host response to bacterial, viral or similar invasion.
Inflammation	A non-specific host response to invasion of foreign material. The goal of the inflammatory process is to remove dead tissue and bacteria. The wound contains yellow, sloughy material and produces exudate. Chronic wounds are often stuck in the inflammatory phase.
Maceration	The skin surrounding a wound can show signs of maceration (thin, shiny, pale, white or grey tissue). Maceration is a barrier to wound healing due to the high risk of skin breakdown. Maceration is often due to leakage of exudate. Therefore the choice of dressing should reflect the exudate level in the wound.
Necrotic tissue	Dead, black or yellow tissue. The necrotic tissue can be soft or can form an eschar.
Persistent pain	Pain that persists with activity and / or at rest
Slough	Deposits of dead white cells, dead bacteria, etc. in the wound bed, yellow in appearance.
Temporary pain	Procedurally related pain, for example at dressing changes, during cleansing or debridement.

This pocket guide, on basic patient & wound assessment and treatment, aims to help health care professionals to assess and manage chronic wounds.

*By facilitating knowledge of basic wound management it is our goal to support **faster wound healing** whenever possible.*



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Introduction to Wound Management

The most important part of wound management is to diagnose the aetiology of the wound and treat or optimise the underlying cause. This will promote healing with the assistance of modern wound dressings.

Wounds heal best in a moist environment and most wound dressings have been designed to assist this process.

As the wound healing is determined by the general health of the patient, a comprehensive assessment of the patient is critical to assist in the planning and evaluation of any wound treatment.

Assess – Treat – Reassess

The circular model outlined below comprises the important elements in wound management. The model is described in details on the following pages.



1. **Assess** your patient and the wound
2. **Treat** underlying pathology and the wound
3. **Reassess** the wound to evaluate the effect of the treatment.

If the wound is healing as expected, continue the treatment as planned. If not, adjust treatment according to the reassessment.

Assess

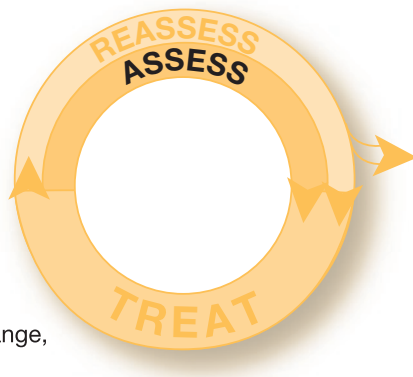
Planning the optimal treatment requires assessment of both the patient and the wound



Assess the Patient

- Full medical history e.g. diseases such as:
 - Diabetes
 - Vascular diseases
 - Immune compromise
 - Connective tissue disorders
 - Allergies
- Medication
- Nutritional status
- Lifestyle
 - Tobacco/alcohol habits, etc.
 - Impaired mobility
- Psychological/psychiatric problems
- Quality of Life

Assess the wound



Assessment of the wound is a prerequisite for the selection of an appropriate dressing

Ongoing assessment is required at each dressing change, carefully recording the following:

- **Location of wound**
- **Wound size** (including cavity, sinus and fistula)
- **Characteristics of wound bed** (necrosis, granulation, infection)
- **Exudate** (none, low, moderate, high)
- **Odour** (absent, present)
- **Clinical signs of critical colonisation / local infection** such as delayed healing, odour, absent or abnormal granulation tissue, new or increased pain at wound site, excessive or increased exudate¹
- **Condition of surrounding skin** (normal, oedematous, white, shiny, warm, red, dry, scaling, thin, etc.)
- **In case of chronic wound pain, determine the kind of pain**²
 - Location (wound bed or other areas)
 - Duration (persistent / temporary)
 - Intensity (on a scale from 0 (no pain) to 10 (worst pain))
 - Quality (aching, throbbing, burning, stinging, shooting, stabbing)

Barriers consisting of local and systemic factors may delay or impede healing. Through the assessment it is essential to identify these factors and control them to facilitate faster wound healing whenever possible.

¹ Refer to the pocket guide: **Clinical Wound Assessment** for further information on bacteria in wounds and dressings with silver.

² Refer to the pocket guide: **Assessing and Managing Painful Chronic Wounds** for further information on wound related pain.

Treat



Following the initial wound assessment the specific points below should be considered when choosing the treatment

- **Leg ulceration**

Ascertain the underlying disease, e.g. venous / arterial. A venous leg ulcer should be treated with graduated compression therapy, whereas an arterial ulcer cannot be treated with compression. If the leg ulcer is arterial, always refer to a specialist.

- **Diabetic foot ulcers**

Always refer to a specialist ³

- **Pressure ulceration**

Relieve or remove pressure to prevent further injury.

- **Patient**

Discuss what issues concern him the most about the wound.

³ Refer to the pocket guide: **Improved Patient outcomes for Diabetic Foot Ulcers** for further information on bacteria in wounds and dressings with silver.

Treat

Ongoing assessment is required at each dressing change.



Treatment decisions and objectives should be based on the underlying wound problem identified in the assessment. As the wound changes, consider adjusting the treatment according to reassessment. For choice of dressing refer to the **Wound Care Model** on page 10.

- **Extensive necrotic tissue**

Consider a referral to a specialist for sharp debridement or maggot therapy before application of an appropriate dressing.

- **Exudate**

Is the amount of exudate increasing / decreasing? Manage exudate. Do not let the wound bed dry out.

- **Critical colonisation or local infection**

Check for clinical signs such as delayed healing, odour, absent or abnormal granulation tissue, new or increased pain at wound site, excessive or increased exudate⁴. Refer to a specialist for decision on need of a dressing with silver and/or systemic treatment.

- **Systemic infection** (i.e. an infection that has spread beyond the wound)

Check for clinical signs such as redness, heat and/or pain in surrounding tissue, oedema, purulent exudate, fever in additions to the signs of local infection. Always refer to a specialist for decision on need of systemic treatment.

- **Condition of the surrounding skin**

Macerated, shiny, red, dry, scaling, thin, etc. Use skin protectants to minimise the effects of exudate. Use emollients for dry and eczematous skin.

- **Wound pain**

Treat the possible cause of the pain and consider local non-pharmacological treatment. For persistent wound pain consider systemic medication and/or local pharmacological treatment, for example ibuprofen incorporated into a wound dressing⁵.

⁴ Refer to the pocket guide: **Clinical Wound Assessment** for further information on bacteria in wounds and dressings with silver.

⁵ Refer to the pocket guide: **Assessing and Managing Painful Chronic Wounds** or further information on wound related pain.

Reassess



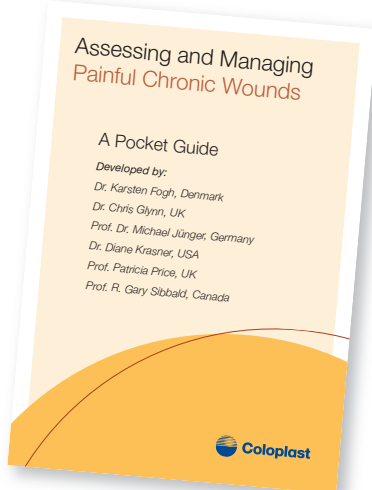
During treatment the wound should be frequently reassessed to evaluate the effect of the treatment.

If the treatment objectives have not been met, consider adjusting the treatment.

Some wounds fail to heal. These wounds require specialist support for further assessment of underlying conditions and to improve clinical outcomes. Examples are fungating wounds, inoperable arterial wounds, patients with end stage renal failure, osteomyelitis, nutritional disorders (e.g. anorexia), and connective tissue disorders.


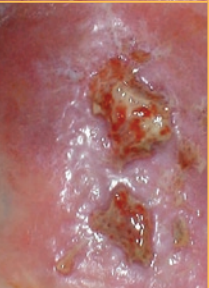

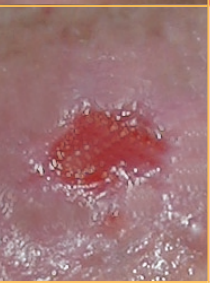



Many patients with chronic wounds experience persistent wound pain that affects their general well-being and influences the wound healing potential.

*The pocket guide **Assessing and Managing Painful Chronic Wounds** provides guidance on treating painful wounds.*



The Wound Care Model

The Wound Care Model shows the appropriate dressing choices. The longer intervals between dressing changes, the more beneficial for the wound healing and cost-effectiveness for the organization.

	Necrotic / sloughy tissue	Local infection / critical colonisation	Granulation	Epithelialization
Wound bed				
Objective of treatment	Removal of necrotic tissue (refer to specialist if in doubt, e.g. in case of necrosis on toe or heel)	Clean up and reduce bacterial burden	Support granulation and tissue growth	Protection of newly formed tissue
Treatment suggestions				
Exudate	Alginate* or similar Hydrocapillary Foam with ibuprofen**	Silver foam Silver alginate* or similar	Foam Alginate* or similar Foam with ibuprofen**	
	Hydrogel + Foam Alginate* or similar Hydrocapillary	Silver foam Silver alginate* or similar	Foam Alginate* or similar Foam with ibuprofen**	
	Hydrocolloid Hydrogel + Foam or Film	Silver hydrocolloid Silver wound contact layer* Iodine*	Hydrocolloid Wound contact layer* Foam with ibuprofen**	Thin hydrocolloid Wound contact layer* Film
				

* In combination with a secondary dressing ** In case of wound pain

When choosing a specific dressing, always remember to consult the "Instructions for Use" for the product.

Coloplast Wound Care Solutions

A number of international suppliers provide wound care dressings. Please find below an overview of the solutions from Coloplast.

Dressing type	Coloplast solution
	Moist wound healing dressings
Alginate	SeaSorb Soft Non-adhesive Alginate Dressing
Alginate filler	SeaSorb Soft Filler
Foam	Biatain Adhesive Foam Dressing Biatain Non-adhesive Foam Dressing Biatain Soft-Hold Foam Dressing
Film	Stabilon
Hydrocolloid thin	Comfeel Plus Transparent Adhesive Hydrocolloid Dressing
Hydrocolloid	Comfeel Plus Adhesive Hydrocolloid Dressing
Hydrocapillary	Alione Adhesive Hydrocapillary Dressing Alione Non-adhesive Hydrocapillary Dressing
Hydrogel	Purilon Gel
Wound contact layer	Physiotulle Non-adhesive Wound Contact Layer
	Dressings with silver for infected wounds
Silver alginate	SeaSorb - Ag Non-adhesive Alginate Dressing
Silver foam	Contreet / Biatain - Ag Adhesive Foam Dressing with silver Contreet / Biatain - Ag Non-adhesive Foam Dressing with silver
Silver hydrocolloid	Contreet / Comfeel Adhesive Hydrocolloid with silver
Silver wound contact layer	Physiotulle - Ag Non-adhesive Wound Contact Layer with silver
	Dressings with ibuprofen for painful wounds
Foam with ibuprofen	Biatain - Ibu Non-adhesive Foam Dressing with ibuprofen Biatain - Ibu Soft-Hold Foam Dressing with ibuprofen

Not all the above solutions may be available in your country. For more information visit www.woundcare.coloplast.com.

Pocket Guides provided by Coloplast

A number of Wound Care Guides have been developed by clinicians for clinicians to help reduce the barriers to healing. The content of the guides is based on clinical experience and the best available evidence.

Pocket guides	Readers	Content
Wound Care Reference Guide	For professionals who need a basic knowledge on management of chronic wounds	Provides a general guideline for basic wound treatment, appropriate choices of wound dressings and when to refer to a specialist
Clinical Wound Assessment	For specialists treating chronic wounds	Provides a general guideline for assessment and treatment of wounds with delayed healing. Focus on evidence-based wound management and critically colonised wounds
Improved Patient Outcomes for Diabetic Foot Ulcers	For specialists treating diabetic wounds	Provides a general guideline for which aspects to cover when treating diabetic foot ulcers
Assessing and Managing Painful Chronic Wounds	For professionals who need a basic knowledge on assessing and managing painful chronic wound	Provides an overview of how to measure pain and how to manage pain in chronic wounds
Persistent Wound Pain Management Guide	For professionals who need a quick ABCD overview of pain assessment	Assess the pain. Be aware of the cause. Consider local. Do we need systemic?
Application and Cutting Guide	For professionals who deal with difficult-to-dress wounds	Provides inspiration on cutting of dressings in special shapes

Check you local Coloplast office for availability of the different guides in your local language or download an English version from www.woundcare.coloplast.com



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